

# **EXPLORING THE NATURE OF PARTNERSHIP BETWEEN AFRICAN TRADITIONAL AND CONVENTIONAL HEALTH CARE IN ETHEKWINI DISTRICT**

Dissertation submitted in fulfilment of the requirements for the Degree in Masters of Technology in Nursing in the Faculty of Health Sciences at the Durban University of Technology

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## DECLARATION

This is to certify that this work is entirely my own and not that of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). This work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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# **ABSTRACT**

## **Background**

The current alarming growth of diseases and complications, especially in Africa, makes the integration of traditional and conventional health practices a priority in medical training, research and planning, and the funding of health services. Unplanned and/or unintended treatment non-compliance and unnecessary deaths from diseases like tuberculosis and Human Immunodeficiency Virus are escalating in spite of health information and/or education, support groups and awareness events. The World Health Organisation recommends Directly Observed Treatment Strategy for illnesses like tuberculosis, and suggests the inclusion of traditional health practitioners in the strategy because they are constantly in contact with the community and could therefore be utilized as reminders, support system, doctors and care givers. Therefore it is a high priority that traditional health practitioners be integrated into partnership with conventional medicine practitioners, as they are considered the entry point to primary health care programmes in South Africa.

## **Aim of the study**

The aim of this study was to explore the nature of the partnership between the African traditional and conventional health care in the eThekweni District.

## **Methodology**

A qualitative, multiple case study design was used to explore the partnership between African traditional and conventional health care within the South African health care system in the eThekweni district of KwaZulu-Natal Province. In attempting to explore and understand the extent to which both these health care systems work together, a qualitative research method was used. All ethical issues were considered after which individual interviews were conducted using

an interview guide and a tape recorder. A cross-case synthesis was used to analyse data.

## **Results**

Results from the study suggest that a partnership is far from being implemented by both the Traditional Health Practitioners and Conventional Health Care Practitioners. It is apparent that they both do not share a common vision. The government has some responsibility and a major role to play in guiding such a partnership and making sure that the South African community is provided with best practices governed by policies and legislation that are transparent, fair and legally binding to everybody involved.

## **DEDICATION**

I dedicate this dissertation to my family for their patience, love, motivation, support and encouragement during this long process.

To my son, Zama, I would really like to thank him very much, for understanding me when I was not available for him even when he needed me. He has always shown that “don’t worry Mom” attitude, I really appreciate that.

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To my God Almighty, I would like to acknowledge His care, guidance and protection that sustained and pulled me through sometimes unfavourable circumstances. My sincere appreciation and gratitude of having been kept in His shadow and enabled to go this far, I consider myself hugely favoured.

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I cannot ignore the tremendous cooperation and humble willingness in going all out to assist me of Traditional Health Practitioners from all over eThekweni. Their understanding and full buy in made it easy for me to carry my study to this level. Not forgetting the clinical nursing practitioners from eThekweni Primary Health Care facilities as well, without whom the study would not have been successful. Their cooperation and contribution to the study is much appreciated.

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## ACRONYMS

Acronym	Full word
AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti-retro viral treatment
ATR	African Traditional Religion
CAM	Complementary and Alternative Medicine
DHIS	District Health Information System
DOH	Department of Health
DOT	Directly Observed Therapy Strategy
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HSRC	Human Science Research Council
KZN	KwaZulu-Natal
MDGs	Millennium Development Goals
OAU	Organisation of African Unity
OMs	Operational Managers
PEPFAR	President's Emergency Plan for AIDS Relief.
PHC	Primary Health Care
SAMA	South African Medical Association
SANC	South African Nursing Council
STI	Sexually Transmitted Infections
TB	Tuberculosis
THP	Traditional Health Practitioner
TM	Traditional Medicine
TMP	Traditional Medical Practitioner
UKZN	University of KwaZulu-Natal
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

# **CHAPTER 1**

## **OVERVIEW OF THE STUDY**

### **1.1 INTRODUCTION AND BACKGROUND TO THE STUDY**

A number of studies reveal that South Africa does not have sufficient health care professionals like other countries (Mokoka, Ehlers & Oosthuizen, 2010; Oosthuizen, & Ehlers, 2007). Despite this, all South Africans are entitled to the professional and ethical health care of their choice without compromise. Patients Charter re-iterates that patients have a right to choose a particular health care provider for services (Department of Health, 2002). According to the World Health Organisation (WHO, 2008), approximately 80% of the population of African Member States use traditional medicine to meet their health care needs. This is further supported by Mander (1998) who states that approximately 27 million South Africans depend on traditional medicine for their primary health care (PHC) needs and regularly visit Traditional Health Practitioners (THPs). In 2007, it was estimated that there were 25000 traditional healers in KwaZulu-Natal (KZN) (Gqaleni, Moodley, Kruger, Ntuli & McLeod, 2007).

In order to meet the Millennium Development Goals (MDGs), the Government has started to pave a way to have THPs and conventional practitioners working together in order to achieve these MDGs (United Nations Summit, 2010). Collaboration between these practitioners is mainly taking place within the field of Human Immunodeficiency Virus (HIV) management and advocacy and is becoming clearer with the HIV Counselling and Testing (HCT) programmes that have been put in place. Should this be well planned and effectively implemented, the African economy could to some extent improve by prolonging the life span of the South Africans that fall within the productive years but die early mainly due to

TB and HIV, as they would work and sow back to the country. This could also help in preserving and maintaining healthy lifestyle.

There is substantial increase in mortality and morbidity due to various ill-health problems like HIV and AIDS, TB and other dreadful diseases like heart, kidney, cancer and other life-threatening diseases. These are threatening to overwhelm the health system and undermine the potential of South Africa to attain the MDG 6 that aims to combat HIV/AIDS, malaria and other disease (United Nations Summit, 2010). It is without doubt that most South Africans consult THPs (WHO, 2008). Therefore, if both the traditional and the conventional practitioners could form a partnership, the country could achieve these MDGs.

Baleta (2004) argues that clients first consult conventional health practitioners, and when they do so they are often also subconsciously thinking along traditional lines. This they do wondering whether they are being bewitched, have ancestral spirits or need to perform certain rituals. Eventually, many of them end up consulting a traditional practitioner. South African traditional practitioners, who were not given their rightful place in the health-care system prior to democracy, are now paving their way back to their original place. To move towards legitimising traditional medicine, the South African parliament proposed that a statutory council be set up to regulate the existing 350 000 traditional healers. The ratio of clients seen by THPs versus conventional practitioners is one practitioner to every 200 or 300 members of the population (Baleta, 2004).

Osakue, Kayode, Marcel and Emmanuel in 2011 Time Taylor International, assert that most of the western, scientific medicines have only been available to the well-to-do, a small proportion of any population. In many developed countries, about 70% to 80% of the population use some form of alternative or complementary medicine, for example acupuncture (SAMA, 2006). According to the National Health Plan of South Africa, "people have the right of access to

traditional practitioners as part of their cultural heritage and belief system”. This was later followed by the WHO recommendations of the need for policies, strategies and guidelines to institutionalise ATM then THPs Bill and finally the THP Act 22 of 2007 (DoH, 2008).

The Traditional Health Practitioners Act in 2007 recognized the potential of traditional medicines and therefore aims to work towards strengthening the partnership with conventional practitioners. The THPs are the key community figures and play a vital role in influencing patients, families and communities at large by contributing to the cultural and spiritual life of the individuals and the community. If there is better understanding of the nature of the partnership, this could strengthen the collaboration between these two practitioners. According to the WHO (2008), its Member States cooperate to promote the use of traditional medicine for health care. The collaboration aims to:

- support and integrate traditional medicine into national health systems in combination with national policy and regulation for products, practices and providers to ensure safety and quality;
- ensure the use of safe, effective and quality products and practices, based on available evidence;
- acknowledge traditional medicine as part of primary health care, to increase access to care and preserve knowledge and resources; and,
- ensure patient safety by upgrading the skills and knowledge of traditional medicine providers.

Due to the role of the THPs in the care and treatment of sexually transmitted infections (STIs) including HIV and AIDS, it has become apparent that they should be involved in referral and treatment, as well as in the promotion of behaviour change (Peltzer, Mngqundaniso and Petros, 2006). Within the current health care system, especially the conventional one, there is no uniformity with regards to patient care and referral system despite the standardized referral

forms that have been put in place for both categories of health care practitioners. Referral is normally expected from the traditional practitioners to the conventional health practitioners. Thus far, this has been happening via official referral letters in some facilities of eThekweni. However, there has not been any form of referral, feedback or communication from the conventional practitioners to the traditional practitioner and this has left a gap. Hence, there is confusion in the patient continuity of care continuum with regards to mixing medication from both practitioners (South African Medical Association [SAMA], 2006). Having worked in KZN as a primary health care nurse (PHC), the researcher has established that traditional healing is the most used health care system in the province. However, it has not been given formal recognition for continuity of patient care, hence the study.

Traditional practice is the most affordable and accessible healthcare system, depending on the type of traditional practitioner consulted for example; spiritual practitioners are said to be the cheapest as they only work with the spiritual gift. Traditional healing has been described by the WHO (2010), as one of the surest means to achieve total health care coverage of the world's population. Nyika (2009) argues that if the ultimate goal of health care systems is to reduce the burden of the disease, it would be unethical to focus only on availability and affordability of African traditional medicines without assessing whether or not the disease burden of the populations is being reduced. Because of cultural sentiments and understanding regarding traditional practices, people do not easily open up about attending both health care systems. Clients therefore often hide their attendance to traditional practitioners because they are afraid of being scolded or ridiculed (SAMA, 2006).

## **1.2 PROBLEM STATEMENT**

Although the Traditional Health Act recognises the role of THPS, these practitioners are not being fully recognized and incorporated into the conventional health sector. There is little evidence of THPs interacting with the government, local health systems or being involved in formal health service delivery. This has left a gap and a certain amount of confusion in terms of the patient continuity of care continuum with regards to mixing medication from both practitioners (SAMA, 2006). There are few clinics in eThekweni district that have initiated the process of partnership with the THPs. However, the nature of this partnership is not clearly defined hence the need for this study.

## **1.3 AIM OF THE STUDY**

The aim of this study was to explore the nature of the partnership between African traditional and conventional health care practitioners in the eThekweni District.

## **1.4 RESEARCH QUESTION**

The research question for this study is:

- What is the nature of the partnership between the African traditional and the conventional health care system in the eThekweni District?

## **1.5 SIGNIFICANCE OF THE STUDY**

In view of traditional practices, it is apparent that there are similarities with the same comprehension of traditional medicine by different writers hence; traditional practitioners have been drawn on in PHC strategies before the advent of HIV/AIDS in various countries. Most conventional practitioners and researchers, however, tend to associate traditional healing with myth, magic, and 'primitive'



culture that use non-scientific techniques, hence the reluctance in conventional practitioners to have close contact with the THPs (SAMA, 2006). The THPs have a vital role to play in this overloaded, with a complex of diseases health care system. A better understanding of how this partnership takes place will add to the growing body of knowledge in the two health practitioners. A case study will be conducted by the researcher to explore the nature of the partnership between African traditional and conventional health care within the South African health care system in the eThekweni district. The results from this study will advance the understanding and aim to pave a way towards working together smoothly with established guidelines. In the absence of strong THP and conventional health practitioner partnerships, findings of the study could influence the formulation of public policy on the use of traditional health practices integrated into conventional health care systems.

## **1.6 OPERATIONAL DEFINITIONS**

### **1.6.1 Allopathic medicine**

A broad category of medical practice that is sometimes called Western medicine, biomedicine, scientific medicine, or modern medicine. This term has been used solely for convenience and does not refer to the treatment principles of any form of medicine described in this document (WHO, 2010).

### **1.6.2 Complementary/Alternative medicine**

A group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine. The terms 'complementary medicine' and 'alternative medicine' are used interchangeably with 'traditional medicine' in some countries. Complementary/alternative medicine (CAM) often refers to traditional medicine that is practised in a country but is not part of the country's own traditions (WHO, 2010).

## **Conventional health care**

Medicine as practised by holders of the title M.D. (medical doctor) or D.O. (doctor of osteopathy) degrees and by allied health professionals, such as nurses, physical therapists, and dieticians (SAMA, 2006). Other terms for conventional medicine include allopathy; western, mainstream, orthodox, and regular medicine; and biomedicine (Digby, 2006).

### **1.6.3 Diviner/*Izangoma***

Diviners, also known as *izangoma* in isiZulu, mainly diagnose illnesses; reveal causes and provide spiritually and socially acceptable solutions. They also while on the other hand cast bones to divine the nature of the illness and to determine the circumstances surrounding the cause of the illness for the divination of the causes of people's complaints. Traditional practitioners get their healing powers directly from their ancestors (Van Wyk 2009). A traditional diviner and diagnostician may or may not have knowledge of medicinal herbs (Republic of South Africa, 2007).

### **1.6.4 Herbalist**

A person who engages in traditional health practice by healing the sick without setting bones or prophesying but get told by the patients themselves the reason for their consultation and is registered as a herbalist under the Traditional Health Practitioners Act 22 of 2007 (Republic of South Africa, 2007).

### **1.6.5 Spiritual healer**

A person who prophesise patients' problems and manages these patients' problems through prayer or using holy water that they pray for (Republic of South Africa, 2007).

#### **1.6.6 Traditional birth attendant**

A person who engages in traditional health practice and is registered as a traditional birth attendant under the Traditional Health Practitioners Act 22 of 2007 (Republic of South Africa, 2007).

#### **1.6.7 Traditional health care**

Health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicine, spiritual therapies; manual techniques and exercises. These are applied singularly or in combination to treat, diagnose and prevent illnesses or maintain wellbeing (SAMA, 2006).

#### **1.6.8 Traditional health practitioner**

A person that is registered under the Traditional Health Practitioners Act 22 of 2007 in one or more of the categories of THPs (Republic of South Africa, 2007).

#### **1.6.9 Traditional health practice**

The performance of a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practice (Republic of South Africa, 2007).

#### **1.6.10 Traditional medicine**

Health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in a combination to treat, diagnose and prevent illnesses or maintain well-being (WHO, 2008).

#### **1.6.11 Traditional surgeon**

A person registered as a traditional surgeon under the Traditional Health Practitioners Act 22 of 2007 (Republic of South Africa, 2007).

### **1.7 CONCLUSION**

South Africa needs all the resources it can get to fight ill-health, poverty and other community-based abnormalities. Different types of traditional practitioners exists world-wide but are labelled differently from country to country and from region to region. This chapter presented the background and purpose of this study. The following chapter will provide relevant literature on traditional and conventional health care.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

This chapter will present the discussion of the relevant literature that will highlight the role and the partnership of the THPs and the conventional practitioners.

In the eThekweni District of KZN province, there is a project headed by a professor from a local KZN university and funded by the United States President's Emergency Plan for AIDS Relief (PEPFAR), which was developed after a series of workshops between traditional health practitioners and the Nelson Mandela School of Medicine at the University of KwaZulu-Natal (UKZN) (Gqaleni, Hlongwane, Khondo, Mbatha, Mhlongo, Ngcobo, Mkhize, Mtshali, Pakade & Street, 2011). The project, which includes a five day training workshop aimed at involving traditional health practitioners in the fight against HIV and AIDS is run by the university, traditional health practitioners and the provincial health department. As a result of the project, patients with HIV now come to the associated clinics early and get the necessary medication on time because THPs are now informed and can talk confidently and openly about some conventional health information to their patients during consultation. Working with traditional health practitioners has also decreased the risk of people or clients being taken in by charlatans who claimed to cure all sorts of conditions including HIV. So far, the programme has been run as a pilot project in a few HIV high-prevalence districts in KZN. Its success has prompted traditional health practitioners in other provinces to call on government to implement it nationally (Gqaleni et al, 2011). This project has played a tremendous role in enlightening everybody involved in the health care system. As one of the traditional health practitioners in the south of Durban states,

*"I can now weigh my patients, write down their recordings, and monitor them as they go along with treatment. I have also developed a good working relationship with the local clinic, and when I see that a patient has symptoms of HIV infection, diabetes or high blood pressure, I refer them to the clinic so that they can conduct tests"* (Integrated Regional Information Network, 2010).

This highlights the success of the project and the possibility of a partnership because this traditional health practitioner has been trained on health issues relevant to her scope of practise.

## **2.2 THE ROLE OF TRADITIONAL HEALTH PRACTITIONERS**

Conventional medicine has become dependent on expensive technological investigations and treatments. As a result has neglected the patient and a holistic approach to patient care (Van Wyk, 2009). On the other hand, traditional African medicine provides a holistic approach to an individual and pays attention to disease as well as issues such as success or misfortune. In most cases in the African traditional ways, certain situations in life are believed to happen not as chance occurrences but rather arise from the unpleasant actions of individuals and therefore angry ancestral spirits according to the balance or imbalance between the individual and the social environment. The practitioners of traditional medicine specialize as experts in particular areas and have separate practitioners for different functions of their profession, in the same way that conventional medical practitioners do. For example, there are herbalists, traditional bonesetters, traditional surgeons, birth attendants, and spiritual healers. Some practitioners combine specializations.

The THPs have multiple roles to play within the society they live in. Some are viewed as traditional health practitioners similar to that of family physicians. If they cannot give medication to the clients, they refer them to specialists like psychiatrists and gynaecologists. In their own sphere, they refer to specialist counter-parts, but also serve as religious consultants who help spiritually. Some practice as fortune tellers as they predict the future. They act as political advisors as many politicians consult with them; and marriage counselors as people with marital challenges consult them to seek whatever help they can get. Help can be physical in the form of treatment, psychological in the form of counseling, or spiritual in the form of prayer. They also act as detectives to search for lost belongings or dead people and social workers where they sometimes help with identification of people for different reasons like deaths or fights amongst family members. They also act as judges where they decide where one should go. By virtue of them providing these forms of interventions they are referred to as public health officers as they determine suitable places for families to stay. Because of the respected role they play in the society, they are given high status as leaders within society (Van Wyk 2009).

Alternative practitioners including traditional health practitioners play an important role in the delivery of mental health care in South Africa. South Africans who suffer from psychiatric disorders are treated by both Western and alternative practitioners, including traditional healers and religious or spiritual advisors (Sorsdahl, Stein, Grimsrud, Seedat, Flisher & Williams, 2010). Most Africans believe that mental disorders are often caused by traditional causes like being bewitched, and that there are ancestral spirits that need to be honoured and if not, people get mentally disturbed. These interpretations suggest that mental health problems are the results of a combination of indigenous, psychosocial, and other causes.

### **2.3 TRADITIONAL MEDICAL PRACTICE AS AN INTUITIVE CALLING**

In the conventional medical field, one decides to be a doctor and studies at a University, while traditional practice is a calling that is ancestral and spiritually based. There is no academic training. However, there is some formal training where one is led by his or her ancestral spirits which is a calling, learn by undergoing treatment as a patient. Upon recovery from illness, some people decide to become practitioners themselves, now having spiritual or ancestral spirits within that were not known before getting sick. In this case, the perception is that ancestors want the person to be a traditional health practitioner. 'Spiritual calling' is another practice where the practitioner diagnoses and gives treatments that are strictly determined by the supernatural powers. Others learn through informal training from a close family member or through a long formal apprenticeship under an established practitioner. During the formal training, the trainees pay their tutor a basic fee as well as a fee for each step of advancement. Some decide to practice because of business and therefore love for the practice. SAMA calls for understanding and tolerance of the role that traditional practitioners play in South Africa in bridging the gap between these two types of practitioners (SAMA, 2006).

The THPs are experienced and skilled in biomedical components of their profession. According to the type of calling an individual has, they have different types of healing methods or powers at their disposal, ranging from fasting and praying to herbal therapies, bathing, massage to surgical procedures. To meet the needs of communities, this calls for bridging the gap on the potential for a health care partnership between traditional African and conventional practitioners in eThekweni and Africa in general. In 2007, the late former Minister of Health, Dr Manto Tshabalala Msimang added the practice of Unani-Tibb, which is one of the African traditional practices, to the list of Allied health professions in terms of Section 16 of the Allied Health Professions Act 63 of 1982. This development sought to move the health sector towards acknowledging African traditional



professionalism (Van Wyk, 2009). Other allied health professions already registered include homeopathy, chiropractic and acupuncture. These professions are usually academic based.

## **2.4 CHALLENGES FACING THE CONVENTIONAL MEDICAL SYSTEM IN THE AFRICAN CONTINENT**

The WHO Traditional Medicine Strategy 2002-2005 identified the following challenges that face the conventional medical system in the African continent:

- facilities are inaccessible for much of the population because of high expenses to get to the health care facilities especially in the rural areas;
- in some urban areas the average waiting time at a hospital or clinic can be as much as 8 hours;
- some staff are poorly trained and unmotivated;
- many staff members believe they have superior knowledge and treat patients inconsiderately;
- patients are frequently not told the nature and cause of their illness;
- there are inadequate technical services leading to poor quality care;
- governments spend a large proportion of their per capita gross national product on western health care than any other health care;
- treatment is divorced from the patient's culture, family and community;
- patients are removed from the family and community, stripped of their identity and forced into a sterile hospital setting, and
- the treatment only addresses a patient's biological manifestation of the illness and does not attempt to heal spiritual aspects of illness (WHO, 2002).

## **2.5 SAFETY, EFFECTIVENESS AND QUALITY OF TRADITIONAL MEDICINE**

Scientific evidence from tests done to evaluate the safety and effectiveness of traditional medicine products and practices is limited (Department of Health, 2009). People do massage and acupunctures as treatment for specific conditions. This form of treatment is believed to be safe and effective as these are taught in academic institutions. Assessing the quality and safety of herbal products might involve some complex and lengthy processes. UKZN, in its programme to incorporate traditional medicine into conventional medicine has established a traditional medicine laboratory to run such processes. The safety, effectiveness and quality of finished herbal medicine products depend on the quality of their source materials and unfortunately, this is prepared and issued by only one person prescribing certain medicine to a particular client at a given point in time. Improvement of the client's condition is evaluated on the basis of evidence from being told by the client or by seeing the obvious recovery, like decrease in swelling of any body part after using medicine. Such observations may suggest effectiveness, but without scientific proof.

As described in De Smet (1999), there is a tendency in the Western oriented biomedical tradition to focus on the risks and down play the role of traditional African medicine and the expertise of traditional health practitioners. Because of the nature of the practice traditional medical practitioners follow, they have their own drawbacks for instance, of no written records about their clients or what and how they do their practices; misdiagnosis; low hygiene standards; and the secrecy of some healing methods. These factors can compromise the quality and safety of traditional health practices.

It has been stated that THPs are well consulted by many people worldwide, but there are still some concerns that have been raised about efficacy, safety, quantity and quality of prescriptions to the public, scientists and non-users.

These concerns are further supported by the fact that there is inadequate clinician experience in combining herbal, traditional or complementary medicine with ARVs in South Africa (Department of Health, 2009). This makes it difficult for the conventional health practitioner to readily accept to work with the THPs especially when there is no evidence based relevance or references confirming the THPs functioning.

Traditional medicine can be used to cure and to kill. According to Stewart, Moar, Steenkamp and Kokot (1999), cases of poisoning with *muthi* (traditional remedies) are not uncommon, and are associated with considerable morbidity. Methods for the detection of a number of the more common herbal toxins now exist. These authors further conducted investigations on *muthi*-poisoning to exclude the extent of *muthi*-toxicity. They discovered that out of 206 fatal cases, 155 were stated to be due to poisoning by *muthi* (Stewart, Moar, Steenkamp and Kokot (1999). In a further 50 cases, the toxin was found to be unknown. However, a compound which was most likely a traditional remedy was detected. This further contributes to the uncertainty of the safety of traditional medical practices.

## **2.6 PATIENT SAFETY AND THE USE OF MEDICINAL HERBS**

Traditional medicines and practices can cause harmful, adverse reactions if the product or therapy is of poor quality, or if it is taken inappropriately or in conjunction with other medicines in some cases where there are drug interactions. For this reason, training, collaboration and communication among providers of traditional and other medicines, as well as patient awareness about safe usage is important (WHO, 2010). However, Nyika (2009) argues that as in the case with Western medicines, further research is needed to better understand potentially side effects that may be associated with traditional medicine. He further claims that harm is not always caused deliberately. This

may be caused inadvertently; hence the need for research in order to improve the efficacy of the African traditional medicines.

## **2.7 CONSTRAINTS RELATING TO THE DEVELOPMENT OF TRADITIONAL MEDICINE**

According to the WHO (2008), traditional medicine has its own challenges of processing and production of the products for use by the public. Lack of partnership and support by other stakeholders like conventional health practitioners and the government is one challenge. There is also another sad lack of the effective production of medicinal herbs; the documentation and the preservation of medicinal herbs. Other constraints include:

- lack of institutional support for production and dissemination of key species for cultivation;
- the low prices paid for traditional medicinal plants by herbal medicine traders and urban herbalists;
- lack of appropriate technology for post-harvest and pre-processing purposes adapted productively and effectively;
- insufficient documentation and scientific experimentation for verification of herbalists' claims; and
- lack of preservation of medicinal extracts for extended shelf life (Kasilo, Kofi-Tsekpo and Busia, 2010).

Based on the above challenges, it is apparent that over and above the lack of support of traditional medicine practice, there are difficulties in taking traditional healing to a higher level with regards to cultivation without forgetting that drugs come from plants. If indigenous plants are to be preserved, highly focused research agenda on ensuring the quality, safety and efficacy of ATM will therefore fulfill a social and ethical obligation by responding to the needs of South Africans in addressing the use of TM (DoH 2008).

## **2.8 NATIONAL GUIDELINES, POLICY AND REGULATION REGARDING CONTROL AND USE OF TRADITIONAL MEDICINE**

The South African government has taken a step in regulating and policing the use of traditional medicine, although implementation is still a challenge with regards to practicalities by the end users, namely the THPs (Republic of South Africa, 2007). There are few academic or reference books for African traditional practices and this makes it difficult to standardise practices and medicines. The only person who is in a position to understand the practice is the one practising it as it is intuitive and can only be explained to the next person without written references. This practice is ancestral driven and experimental in nature, depending on individual gifts like herbalist, bone setter or faith healer. This somehow makes it difficult for the DoH to standardize policies as there are no written references or literature. It is apparent that whether the government or conventional health care practitioners believe that South Africans still attend traditional health care or not, they do so and sooner or later this will have to be addressed accordingly. Eventually the government will have to give some guidance through policies.

Most countries do not have national policies for traditional medicine but South Africa has taken a big step in developing the Act (Republic of South Africa, 2007). Regulating traditional medicinal products, practices and practitioners is difficult due to variations in definitions and categorizations of traditional medicine usage and therapies. Herbal products could be defined differently in different countries depending on their use. Regulating the control and use of traditional medicines is therefore complex and needs countries to individualize their national policies.

## **2.9 GLOBAL TRENDS IN TRADITIONAL MEDICINE**

Globally, traditional medicine is well practised and acknowledged. Because of its status world-wide, the researcher will give a broader view of the traditional medicine establishment, comparing international, continental and national views according to individual countries and their practices.

### **2.9.1 China**

Globally, China seems to be more advanced in implementing traditional medicine without compromise. Over the last century, traditional Chinese medicine has co-existed with conventional medicine with traditional medicines accounting for between 30% to 50% of total consumption (Lim, Park & Han, 2009). There are more than 2500 Chinese traditional medical hospitals with about 350 000 working staff members in China. 95% of general hospitals have units for traditional medicine with doctors providing both traditional and conventional medicine. There were about 525 000 in 1995 and the number has obviously increased. Among these THPs, there are 257 000 traditional medical doctors who graduated from traditional medical universities with the knowledge of both traditional and conventional medicine, 10 000 conventional medical doctors retrained in traditional medicine, 83 000 pharmacists who are specialists in herbal medicines and who have graduated from traditional medical universities, 72 000 assistant traditional medicine doctors, and 55 000 assistant herbal pharmacists trained in traditional medicine secondary schools.

Not many countries have such distinct and high numbers of people involved in traditional practices with the government, universities and community involvement especially not in South Africa. In China, the integration of traditional medicine with the national health care system and the integrated training of health practitioners are both officially promoted. The Government of China has reinforced its commitment to the integration of traditional and conventional

medicine on a number of occasions with its Article 21 of the Constitution of the People's Republic of China adopted in 1982 (Lim, Park & Han, 2009).

Traditional Chinese medicine used to be taught through apprenticeships. Now, there are 57 secondary schools teaching traditional Chinese medicine, with an enrolment of 29 000 students. There are also 28 universities and colleges of Chinese traditional medicine and pharmacology, with a total enrolment of 46 000 students, including 2800 undergraduates. Together, these universities and colleges provide 14 professional undergraduate programmes along with programmes for Masters and Doctoral degrees. A chiropractic college is presently being established. In order for one to qualify as a physician of traditional Chinese medicine, the candidate must typically complete five years of study. Admission standards to colleges or universities generally require completion of middle school (seven grades), but there is some flexibility. In some colleges, a primary school education (four grades) is sufficient. Every traditional or conventional medical school contain a unit or department of both faculties with 10% to 20% of the teaching in conventional medical schools allocated to traditional medicine (WHO, 2001). Health insurance covers both conventional and traditional medicine.

### **2.9.2 Australia**

In Australia, traditional Chinese medicine is provided to all patients, including infants. Two out of three patients are female, 50% have a tertiary education, and over 80% have English as their first language. This suggests that all classes of Australians, educated and uneducated do use and do believe in traditional medicine. The number of traditional Chinese medicine programmes offered by universities and private colleges is growing. Programmes, some of which lead to diplomas, range from 50 hours to over 300 hours. There are also traditional Chinese medicine programmes available for qualified conventional practitioners. These programmes are offered within the schools of Applied Science or Health

Science (WHO, 2001). Traditional medicine is officially and openly practised by all in this country, traditional and conventional training is offered equally without prejudice.

Other countries have training colleges for Traditional medicine up and running and have academic products with evidence based practices. The South Australian college of Natural Medicine for educational services for the Traditional Chinese Herbal Medicine and Beauty Therapy passed a re-registration audit that will be valid until 2015. This Traditional medicine college caters for national and international students. Nutritional Medicine, Muscular skeletal therapy, Western Herbal medicine and Homeopathy in addition to a Bachelor of Health Sciences in Acupuncture and naturopathy and other short courses are offered at Endeavour College with spiritual and meditation books published as well (Lim, Park & Han, 2009).

### **2.9.3 Northern Korea**

Northern Korea has put some efforts in utilizing and integrating Traditional medicine system into Conventional medicine. They have integrated Traditional Medicine into education and clinical practices. School curricula have both types of medicines but Traditional medicine has more weight. In this country, the government is the driving force for an integration policy from as far back as the 1950's. However, it has limited resources for research which hinders scientific advancement. There are about twelve colleges that have both traditional and conventional medicine training. All these colleges have a one or two year reorientation programme on traditional medicine. Pharmacy systems have dual practices of traditional and conventional training from Koryo Pharmacy College as well as drug manufacturing and dispensing. However, traditional health practice is restricted from handling western drugs and vice versa. Doctors are



trained using separate educational systems. The medical delivery system is from primary clinics to hospitals (Lim, Park & Han, 2009).

Traditional medical doctors, known as Koryo doctors can provide combined treatments to patients, based on their own knowledge and resources and this seems to work more efficiently than treatments provided exclusively by two qualified physicians. It is unclear as to how far the range of each qualification overlaps. The North Korean government allowed traditional Korean doctors to prescribe western drugs and to be allocated to work in western hospitals and participate in surgical operations. Western doctors are allowed to use acupuncture which is a traditional practice, and prescribe Korean drugs without restrictions. In South Korea, integration caused professional tension and exclusivity in practical modalities (Lim, Park & Han, 2009).

#### **2.9.4 Cambodia**

In Cambodia, the Ministry of Health has established the Centre for Traditional Medicine, which is limited to basic work in a few botanical medicines and has little input into pharmaceutical issues. Much of the knowledge available on botanical specimens is based on their use in neighbouring countries. Shops throughout the country sell traditional medicines from around the world. As far as education and training is concerned, there is no officially recognized curriculum incorporating the use of traditional medicines (WHO, 2001).

#### **2.9.5 Luxembourg**

Reimbursed at 80% of fees, homeopathy is the only officially covered complementary/alternative practice. In the case of other complementary/alternative therapies, there is no specific reimbursement rate in the list of publicly covered medical acts and services, meaning that, they are not covered by public health insurance. However, when these are legally provided by

a recognized allopathic health care professional, complementary/alternative treatments are unofficially reimbursed in the context of a normal consultation. Approved allopathic physicians are thereby free to choose the treatment they provide. There are no private insurance companies offering coverage for complementary/alternative medicine. There is no officially recognized complementary / alternative medical training in Luxembourg (WHO, 2001).

### **2.9.6 India**

India is also one of many countries that practise traditional medicine widely, especially in rural areas where 70% of the Indian population lives. There are 2860 hospitals, with a total of 45 720 beds, providing traditional Indian systems of medicine and homeopathy. In 1998, more than 75% of these beds were occupied by patients receiving ayurvedic treatment, which is by far the most commonly practised form of traditional medicine in India. There are 22 100 dispensaries of traditional medicine. With regards to regulation of the practice of Ayurveda, unani, siddha, naturopathy, homeopathy, and yoga are all recognized by the Government of India. The first step in granting this recognition was the creation of the Central Council of Indian Medicine Act of 1970. The main mandates of the Central Council are as follows:

- to standardize training by prescribing minimum standards of education in traditional medicine, although not all traditional medicine practitioners and homeopaths need be institutionally trained to practice;
- to advise the central Government in matters relating to the recognition/withdrawal of medical qualifications in traditional medicine in India; and
- to maintain the central register of Indian medicine, revise the register from time to time, prescribe standards of professional conduct and etiquette, and develop a code of ethics to be observed by practitioners of traditional medicine in India. All traditional medicine practitioners and homeopaths must be registered to practice. Few people besides State employees have

medical insurance, although this insurance does cover traditional medicine (WHO, 2001).

## **2.10 TRADITIONAL MEDICAL PRACTICES IN AFRICA**

Generally, in Africa it is believed that health, sickness and healing have a religious association. The existence of God and other spiritual beings is never in doubt (Van Wyk, 2009). The concept of Africanism is about physical, social and spiritual linking to God, self and society. Therefore, healing should take the same approach which will stabilize the person's equilibrium. For an African child, a holistic approach to healing the mind, body and soul is of utmost importance and can never be replaced by any other healing means that will bring inner peace. Treating diseases should be approached from treating the cause and preventing misfortunes. The spiritual wellbeing of an individual is important as in Maslow's hierarchy of needs. It is a basic need as it brings inner peace and harmony with the ancestors. However, what is of utmost importance is the well-being of the society at large and not just a single individual as the latter needs to interact with the whole healthy society.

The WHO Report (2002) acknowledged THPs as a key resource in HIV and AIDS prevention and care, and stressed that an effective response to the pandemic requires collaboration between traditional and conventional health providers which is not yet happening. Generally, people have a lot of faith in THPs because they are constantly in touch with them as they live with them in the communities. They see them as part of their society who are able to reach to their inner being spiritually, socially or otherwise. Even when they are diagnosed as HIV positive or to be put on TB drugs, they still come to seek THPs opinion (Integrated Regional Information Network, 2011). It is estimated that the number of traditional practitioners in Tanzania is 30 000 - 40 000 in comparison with 600 conventional doctors. Similarly, in Malawi, there is an estimated 17 000 Traditional Medical Practitioners (TMPs) and only 35 medical doctors in practice

in the country. For this reason, there is a need to involve TMPs in the countries' national healthcare systems through training and the evaluation of effective remedies, as they are a larger and more influential group in PHC.

### **2.10.1 Botswana**

Practitioners of traditional medicine provided the only health care services available in most of Botswana until the first part of the decade following independence in 1966 (WHO, 2001). The recent introduction of conventional services throughout the country appears to have reduced the influence and activities of traditional medical practitioners, but only to a limited extent and mainly with respect to younger and more formally educated population groups. THPs are well respected and influential in rural areas and remain central figures in the everyday lives of the majority of the rural population. There are about 3 100 THPs in Botswana, approximately 95% of whom reside in rural areas. The first reference to the official acceptance of traditional medicine practitioners in Botswana appears in Section 14.86 of the National Development Plan of 1976-1981 (WHO, 2001). The traditional health practitioner (*ngaka* in seTswana language), performs a significant role in Botswana, especially in the rural areas. The policy of the Ministry is to evaluate further the contribution of traditional healers to the health care system of the country and possibly then to seek ways of closer cooperation and consultation.

There are a large number of traditional health practitioners of various types who are frequently consulted on health and personal matters. The Ministry of Health will continue its policy of gradually strengthening links with traditional health practitioners including diviners, herbalists and faith healers. The emphasis will be put on improving mutual understanding, especially about the practices and techniques of the traditional practitioners. No full-scale integration is envisaged,

but referrals between modern health care services and traditional health practitioners will be encouraged where appropriate (WHO, 2001).

### **2.10.2 Angola**

Although there is a registry of THPs, there are no official legislative or regulatory texts governing the practice of traditional medicine, neither licensing procedures for traditional medicine practitioners, nor system for the official approval of traditional medical practices and remedies, and no local or national councils in charge of reviewing any problems concerning traditional medicine. Traditional medicine practitioners are not involved in Angola's primary health care programme either at the local or national level. Angola does not have any official training facilities or programmes for traditional medicine (WHO, 2001).

### **2.10.3 Cameroon**

When Cameroon was planning for their Social, Economic, and Political Development Plan of 1981-1986, measures were to be taken to lay down a joint strategy method to effectively integrate traditional medicine into the national health plan by implementing a program on traditional medicine in conjunction with some of their neighbouring countries. Legal Status of Traditional Medicine and Complementary / Alternative Medicine: Cameroon created the Traditional Medicine Service within the Unit of Community Medicine in the Yaounde Central Hospital and set up the Office of Traditional Medicine in the Ministry of Public Health (WHO, 2001).

A number of research projects on traditional medicine and training programmes for traditional medical practitioners have taken place. Local officials are allowed to authorize the practice of traditional medicine in their administrative and / or health subdivisions, and some traditional medicine practitioners are involved in Cameroon's primary health care programme (WHO, 2001).

## **2.11 TRADITIONAL MEDICINE IN THE SOUTH AFRICAN CONTEXT**

South Africa is now recognizing traditional medicine after a long time of not acknowledging its practice. This recognition is supported by Peltzer (2004) who claims that "for the first time in our history, the potential of traditional medicines is being recognised and they are taking their rightful place in our health system." A few years ago, the late Minister of Health and the KZN Premier proposed collaboration and integration of traditional and conventional medicine. About 350 000 South African THPs are not really regulated to practice jointly with conventional health practitioners in South Africa. For this reason, South Africa's parliament proposed that a statutory council be set up to regulate traditional healers (WHO, 1998).

### **2.11.1 The regulatory situation**

Research on herbal or traditional medicine is very limited and thus has not been regulated for purity and potency (Department of Health, 2009). The WHO Traditional Medicine Strategy 2002-2005 (WHO, 2002) provided a strategy framework for action to promote the use of TM/CAM Medicine in reducing mortality and morbidity, especially amongst impoverished nations. This strategy focused on four objectives: policies, promoting safety, efficacy and quality, access and the rational use of TM/CAM. This was adopted in 2000 and endorsed in 2001 by the Organization of African Unity (OAU) for a decade after which a 12-member WHO regional expert committee on TM was set up to assist countries to accelerate the implementation of policy decisions.

Despite the wide use of traditional health practices, genuine concerns have been raised from the scientists/conventional health practitioners and the enlightened public about efficacy, safety and quality of traditional medicine, to meet the criteria needed to support its use world-wide. With the rate at which globalization is taking place, people are getting more and more westernized. As a result, they

are shifting away from their traditional ways or if they find themselves having to deal with traditional practices they want to know more about what they are given regarding safety and efficacy. This poses a challenge in the traditional health sector as there is inadequate clinical experience in combining herbal, traditional or complementary medicine with ARVs (Department of Health, 2009). There are no adequate health care policies, or accepted research methodologies for evaluating traditional medicine. Therefore, research into the safety and efficacy should be promoted, and the quality of the research needs to be improved. Recently, the UKZN has started a laboratory to test the efficacy, and quality of traditional medicines.

The South African government has made significant efforts in the recognition of traditional medicine and trying to incorporate the traditional medicine sector into the national health care system by developing the Traditional Health Practitioners Act 22 of 2007. Another example is the Human Science Research Council (HSRC) which helped in the standardization of African healers practice in the area of HIV and AIDS (Mngqundaniso, 2006). Despite all that is in place, the Department of Health is not yet fully on board in terms of practices, as there is no cross-referral and joint care from the conventional sector to the traditional practitioners. As Devenish (2005) notes, “although the Department supports a system of collaboration on PHC and HIV and AIDS prevention and education, at present the Department does not support referrals from the formal health system to traditional practitioners, principally because of a lack of research and regulation around the dosage and efficacy of traditional treatments”. Even though collaboration between the two sectors is happening, there has not been much enthusiasm in integrating the two systems in a manner that allows freedom of attendance and practice between patients and the health care providers.

### **2.11.2 Training in relation to traditional practices**

Although a number of training interventions for traditional practitioners in HIV and AIDS have been conducted in South Africa, there have been no systematic evaluations of health care training for South African traditional practitioners (Leclerc-Madlala, 2002). In South Africa, there is also other alternative traditional medical practice training available. There are three categories of CAM: The first group includes acupuncture, chiropractic, herbal medicine, homeopathy and osteopathy. The second category includes aromatherapy and hypnotherapy; and the third one includes therapies that are long established and are culture based, like crystal therapy. However, there is no available evidence of efficacy of these practices.

Doctors and nurses with sufficient knowledge of CAM therapies can guide clients utilizing both traditional and conventional medicine within a holistic approach of changes in lifestyle, complimented by CAM therapies. According to Van Wyk (2009), a curriculum to prepare doctors, nurses and allied health professionals to take part in integrative health care should include knowledge and skills in:

- clinical nutrition, physical activity and behavioral change;
- mind-body therapies, herbs and supplement;
- working with spirituality and stress physiology; and
- alternative therapies that the local people commonly utilize, such as traditional Chinese and African medicine, homeopathy and osteopathy.

In support of traditional healing, Siddharth (2006) suggests that academics should further refine graduate education to include ethnomedical competence. Despite the traditionalism in conventional medical practice there is a great prejudice and misconception about African Traditional Religion (ATR) as most conventional medical practitioners scorn and look down upon it. Traditional health practices are regarded as unscientific, pagan, as one would recall that *inyangas* were referred to as “witch doctors” in the past.



THPs are regarded as general health practitioners, community health workers, psychiatrist and social workers, counselors who listen to other people's problems. Herbalists, because of their nature of their practice, are regarded as the pharmacists of Africa who are not divinely called to the profession but learn from family members who have been occupying the same position. A traditional practitioner is also looked at from a religious point of view because diviners who form part of traditional healing heal the sick through divine assistance and intervention. They uncover the secrets behind their client's sickness by consulting the ancestors for information about the real cause behind the sickness. Because of their community involvement and trust, In 1974 after the Geneva Conference, the United Nations Children's Fund (UNICEF)/WHO, recommended that traditional medical practitioners and traditional birth attendants be trained in PHC (WHO, 2010).

According to the Traditional Health Practitioners Act 22 of 2007, traditional health practice means the performance of a function, activity, process or service based on a traditional philosophy that includes the utilization of traditional medicine and traditional practice. The Traditional Health Practitioners Act of 2007 defines traditional philosophy as "indigenous African technique, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines communicated from ancestors to descendents or from generation to generation, with and mostly without written documentation, whether supported by science or not, and which are generally used in traditional health practice" (Republic of South Africa, 2007).

Traditional healing process is holistic in nature, involving the whole person and family. The aim is to restore the individual's equilibrium by ensuring physical, social, spiritual, psychological and ecological wellness. According to the WHO as cited by Abdullahi (2011), the THPs are individuals who are recognized by their communities as competent to provide health care services using a range of

substances and methods based on the community's social, cultural and religious systems.

## **2.12 INCORPORATING TRADITIONAL PRACTICE INTO THE CURRENT CONVENTIONAL HEALTH CARE SYSTEM**

In a democratic and liberated South Africa, people are free to choose health care providers of their choice. Now, with an escalating HIV and TB infection rate, people consult both THPs and conventional health services. Both these health care sectors need to develop models for collaboration to enable clients to enjoy quality health care, and to provide them with the right to use the health care provider of their choice. People have the right to choose health care providers of their choice, while on the other hand there could be integration of both health care systems. The South African Government has taken a step by promulgating the Traditional Health Practitioners Act 22 of 2007 and now needs to implement policies as it is done in the conventional medicine sector, to support the traditional health sector. In her speech, the late former Minister of Health, Dr Tshabala-Msimang emphasized the need to conduct more research on traditional medicine and medicinal plants to prove the efficacy of these medicines (Department of Health, 2008).

The South African Government has formed a directorate that is responsible for traditional health matters in the Department of Health in order for the traditional healing sector to succeed (Republic of South Africa, 2007). At a community health care level, THPs have been trained on HIV and AIDS care and have been participating in some studies related to treating HIV and AIDS. A Public Private Mix is in the process of being implemented for conventional health care providers to work with traditional practitioners, led by the Department of Health.

Traditional healing continues to struggle for formal recognition, legal protection and control, but they have already achieved something (Republic of South Africa, 2007). Despite achievements made by the government, non-governmental organizations like the University Research Council and independent researchers in promoting the incorporation of traditional practices, much still needs to be done with regards to legalizing traditional practices and having the two sectors working together.

### **2.13 STATISTICS OF TRADITIONAL AND CONVENTIONAL DOCTORS AVAILABLE IN SOUTH AFRICA**

It was expected that traditional healers would diminish as people become urbanized (Sherrifs as cited by Ndhlala, Stafford, Finnie and Van Staden, 2011). The Department of Health estimates that there are 200 000 traditional practitioners in the country that consult for a variety of traditional medicines and that there are 3622 allied health practitioners that are registered for a variety of complementary alternative medicines (Gqaleni et al., 2007).

### **2.14 MAKING PLANTS INTO MEDICINE-THE TECHNOLOGY OF HERBALISM**

Connecting with the ancestors is of vital importance as it brings out healing power and sensitizes the ancestors to release power and bless the process. Calling on the plants' spirit with ceremony and prayer brings it into aliveness and turns it into true medicine as healers are connected to their spiritual or ancestral divines. When the UKZN began to work with the traditional practitioners, they had to slaughter a cow to appease the ancestors in order to get their blessings. According to Buhner (2006), plants are generally taken as medicine in four ways:

- In water as infusions or decoctions;
- Tinctures from extended immersion in an alcohol and water combination;
- Salves from transferring the power of the herb to an oil base; and

- In an unchanged state either by chewing or eating the root or grinding the plant and taking it directly or indirectly in capsule form.

In the screening of Sub-Saharan African plants used in traditional medicine for anthelmintics, it was discovered that since resistance to widely used anthelmintic drugs such as levamisole, mebendazole and pyrantel is currently a problem with livestock, and also a growing concern in the treatment of human helminths, a levamisole resistant strain of the nematode *Caenorhabditis elegans* was used in motility. Seventeen plant species were selected for investigation based upon their traditional uses in Sub-Saharan Africa for gastrointestinal diseases. Anthelmintic screening of 17 Sub-Saharan African plant species confirmed the traditional use of 12 of these plants for intestinal infections (Waterman, Smith, Pontiggia & DerMarderosian, 2010).

## **2.15 ETHNOPHARMACOLOGICAL RELEVANCE**

Species of *Podocarpus* are used traditionally in their native areas for the treatment of fevers, asthma, coughs, cholera, chest complaints, arthritis, rheumatism, venereal diseases and distemper in dogs. Five plants used in traditional medicine in the Western Cape Province, have been investigated for anti-mycobacterial activity: *Olea capensis*, *Tulbaghia alliacea*, *Dittrichia graveolens*, *Leysera gnaphalodes* and *Buddleja saligna* (Bamuamba, Gammon, Meyers, Dijoux-Franca & Scott, 2008).

The WHO Traditional Medicine Strategy 2002-2005 provided a framework for action to promote the use of TM/CAM in reducing mortality and morbidity, especially among impoverished nations. The strategy focused on four objectives:

- Policy, which aims at integrating TM/CAM into national health care systems, where appropriate, by developing and implementing national TM/CAM policies and programmes;
- Promoting safety, efficacy and quality by expanding the knowledge base of these remedies and by providing guidance on regulatory and quality assurance standards;
- Access to increase the availability and affordability of TM/CAM where appropriate, focusing on poorer populations; and
- Rational use, which promotes the therapeutically sound use of appropriate TM/CAM by providers and consumers (WHO Traditional Medicine Strategy 2002-2005).

## **2.16 CONCLUSION**

This chapter reviewed literature on the partnership between the THPs and conventional health practitioners. Although South Africa promulgated a Traditional Health Practitioners Act in 2007, literature reveals that there are challenges in incorporating THPs into current conventional health care. The next chapter presents research methodology.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

This chapter will address methods used in the research design; the research setting; sampling process; data collection; data analysis and ethical considerations.

#### **3.2 RESEARCH DESIGN**

A qualitative, multiple case study design was employed in this study. A case study method is ideal in exploratory studies as the researcher sought to explore the extent of a partnership (Yin, 2009). Case studies are used by researchers in order to thoroughly explore a programme, an event, an activity, a process, one or more individuals, but families, groups, institutions and other social units may also be the focus (Yin, 2009; Polit and Beck, 2008). A case study design was chosen for this phase because it allowed the researcher to explore the nature of the partnership between African traditional and conventional health care within the South African health care system in the eThekweni district.

#### **3.3 SETTING**

EThekweni District is sub-divided into three Sub-Districts: the North which covers a population of about 1,175,774, the West covering about 773,493 and the South sub-district which covers about 1 257 569 making a total of 3,206,836 people eThekweni District Health System (2011). EThekweni District has a population which is considered deprived and poor because of lack of employment opportunities; illiteracy; inaccessible government services like children's birth registration, social grants and the like, for both males and females. It is also

industrial, urban and peri-urban area. Community lifestyle is determined by cultural and traditional customs and a religious and westernized culture. Ill health is still largely attributed to witchcraft and supernatural forces and western causes in some instances. The study took place in the whole of the eThekweni district covering the *North*: Inanda Community Health Centre (CHC); *South*: Folweni, Lamontville and Cato Manor clinics; and *West*: Chesterville, Clermont and Valley Trust clinics of the eThekweni district. These facilities are already working with both sets of practitioners. In the clinic committees, there may possibly be THPs as committee members.

With an estimated 5, 6 million people living with HIV in 2009 in South Africa (UNAIDS, 2010), KZN is the epicentre of the HIV and AIDS epidemic with an estimated 39, 5% (Department of Health, 2010). As previously stated in Chapter 2, a district-based collaboration between provincial and local authority clinics and THPs was undertaken in order to address HIV and AIDS prevention, testing and care in KZN. The main sponsor of the project was PEPFAR and involved UKZN, KZN Department of Health, eThekweni Municipality Health Unit and KZN THPs (Gqaleni et al., 2011).

### **3.4 SAMPLING PROCESS**

Participants were selected using sampling of key informants from traditional and conventional health practitioners. Purposive sampling combined multiple case studies and snowballing methods were used to get the depth of the investigation. The sample consisted of consenting PHC nurse clinicians who consult clients as they get to be seen by any registered or professional nurse, and all types of THPs that were in partnership with the clinics. This sample is representative of all participating parties in the health care system. When conventional health care workers consult clients who come with referral letters, referral letters do not specify whether the client has attended a herbalist or a faith healer or any other

specified traditional practitioner. As a result of this, the researcher was unable to focus on certain groups of THPs and not others. Therefore, all types of THPs were included in this study. The sample comprised of two focus group discussions, one comprising of ten participants and another one comprising of eight participants, and individual interviews with 24 THPs and 12 conventional health practitioners. Below is a table that illustrates the demographic profile of the participants.

**Table 3.1: Participants' demographic profile**

<b>Criterion</b>	<b>No of participants</b>	<b>Designation</b>	<b>Experience</b>	<b>Qualifications</b>
All THPs	24	Diviners, faith healers, herbalists	Between 0-35 years of experience	Police, educator and no formal tertiary qualification
Individual THPs	22	Diviners, faith healers, herbalists	Between 3 and 40 years	1 police woman, 1 educator
Trainees	2	Diviners	Between 0-1 year	Matric only
FGD 1	10	Diviners and faith healers	Between 5-35 years	No formal tertiary qualification
FGD 2	8	Diviners, faith healers and herbalists	Between 6-30	1 police woman, the rest had no formal tertiary qualifications
All CHPs	12	Clinical nurse practitioners including Operational Managers	Between 8-35 years of experience	Registered nurses
CHP	5	Operational Managers	Between 15-35 years of experience	Registered nurses



### **3.5 DATA COLLECTION**

In-depth interviews with a structured interview guide and open-ended questions were conducted with conventional health care practitioners and THPs. Use of any available documents like THPs referral letters as evidence of partnership was also used. Although referral is supposed to be a two way process, it is normally from THPs and therefore referral forms from the THPs have been used. Scheduled visits were then used to collect data from the participants referred to above. Amongst these participants, there were individual and focus group discussions of THPs. An interview guide was used to facilitate the discussions. The guide was translated into isiZulu (Appendix 3). Focus groups participants were interviewed individually within a group followed by open discussions where everybody was allowed to talk as they remembered points they might have omitted, understood the context and as they felt free to express themselves openly within and amongst each other. Data was then voice-recorded and data collection continued until a saturation point was reached.

### **3.6 DATA ANALYSIS**

Pattern matching, explanation building, time series analysis and cross-case synthesis were used as strategies for analysing case studies as suggested by Yin (2003). Collected data was analysed and interpreted.

### **3.7 TRUSTWORTHINESS**

Yin (2003: 34) suggests four tests that are relevant to establish the quality of empirical research such as case studies. These are (a) construct validity, (b) internal validity, (c) external validity and (d) reliability. To enhance the quality of the research design and of the study as a whole, the researcher used these tests for both the study and the tools. Below is the breakdown of the four tests applied by the researcher in order to ensure trustworthiness.

### **3.7.1 Construct validity**

The multiple sources of evidence were ensured through triangulation. Structured interview guide was used to interview focal groups as well as individual participants until the saturation point was reached. Referral letters from the THPs to facilities with detachable acknowledgement receipts were also used as evidence in record reviewing. Data triangulation was ensured through the use of multiple cases. See Table 1.

### **3.7.2 Internal validity**

Internal validity was ensured through pattern matching which was done through cross case analysis. This was done through interview guide that was repeatedly conducted to different participants of two focal groups and individual groups. Results from the participants' responses suggested evidence to support that the tools that were used reflected the truth of the data that was collected and interpreted.

### **3.7.3 External validity**

External validity of the case study means establishing the domain to which the study's findings could be generalised. However, case studies cannot be generalised. Yin (2003) argues that case studies rely on analytic generalisation. According to Yin, analytic generalisation does not mean trying to select a representative case or set of cases but means that the researcher should try to generalise findings to theory. In this study, pattern matching was used. The same results were found in all responses from all participants who were interviewed until the saturation point was reached, for the above reasons, results found were conclusive to be generalised.

### **3.7.4 Reliability**

Reliability was achieved through the use of a case study protocol during data collection. The case study protocol guided the data collection process. In-depth interview guide was repeatedly used to different participants of focal groups and individual groups of which consistent responses from these participants led to the conclusion that the tool that was used to collect and analyse data was reliable.

## **3.8 ETHICAL CONSIDERATIONS**

The proposal was approved by the Durban University of Technology, Faculty of Health Sciences Ethics Committee. A letter requesting permission to undertake the study, detailing the conditions of participating in the study like confidentiality, privacy or termination of agreement was submitted to the District Manager (Appendix 1). The participants were asked for permission of inclusion in the research and were given information about the study and the research purpose (Appendix 2). The researcher ensured that all necessary steps were followed to ensure that the study was within ethical expectations and that participants' rights were protected by giving them all the necessary information pertaining to the study, explaining that they were not obliged to participate in the study. The purpose of the study, anonymity, confidentiality, privacy, rights, freedom of choice to participate or withdraw at any time they felt they wanted to or as a need arose were all considered and clarified to participants. No names or identities were disclosed in this study. Data was kept separate under lock and key. In reports, no names were mentioned to maintain anonymity, confidentiality and privacy. The researcher ensured that services were not interrupted during data collection and that participants were free from harm. Table 1 lists the quality of case study design and tools (adapted from Yin, 2003).

Table 3.2: Quality of case study design and tools

<b>Case study</b>		
<b>Test</b>	<b>Case study tactic</b>	<b>Phase</b>
Construct validity	Multiple sources of data were used (Triangulation) A chain of evidence was established The key informants were given the opportunity to review a draft of the case study report	Data collection  Data collection  Composition
Internal validity	Pattern-matching was performed Explanation-building was performed	Data analysis Data analysis
External validity	Used theory in Single case study theory was used Used replication logic was used in multiple-case studies.	Research design  Research design
<b>Data collection tools</b>		
<b>Test</b>	<b>Tools tactic</b>	<b>Phase</b>
Content validity		
Construct validity	Multiple sources of data were used (Triangulation)	Data collection
Reliability	Internal consistency	Data collection
	Definition of terms used	Composition
	Triangulation	Data Analysis

### 3.9 CONCLUSION

This chapter described how the research itself was carried out and how data was collected. The sample chosen was appropriate for the data to be collected as it targeted people involved in the practice in some way or another. A qualitative research methodology and data triangulation was implemented. Chapter 4 will present the results of this study.

## **CHAPTER 4**

### **PRESENTATION OF THE RESULTS**

#### **4.1 INTRODUCTION**

The findings of the study will be presented in this chapter. The sample comprised of THPs and conventional health care practitioners that provide health care services in eThekweni District. The first interviews conducted were of individual THPs of different categories like faith healers, herbalists, bone setters and those with multiple ancestral gifts from the South central sub-district of eThekweni. Out of those interviews, the researcher discovered that some individuals were leaving out some valuable information when interviewed individually and would want to come back and say what they had left out at a later stage in a focus group.

The researcher then decided to use the key informants to form two focus group discussions (FGDs) which were conducted with THPs of the same categories. Two FGDs were conducted. The first focus group was from the Western sub-district led by the Inkosi for the local area who was also the chairperson for the local area THPs. The interviews were held at kwaNyuswa tribal court. It consisted of ten THPs of all different types. The second group was from the South sub-district and consisted of five participants of all THP types. The FGD took place in the home of one of the THPs who is also the area clinic-THP chairperson at Folweni area.

Twelve registered nurses from the PHC clinics that had formed partnerships with THPs were interviewed individually using open ended questions. Group and/or individual response will be discussed separately. The discussions were guided by the study objective which was to explore the nature of the partnership between the African traditional and conventional health care in the eThekweni

District. Interviews were conducted within a period of three weeks without interrupting the clinic working settings. To avoid disturbances of the clinic activities, the researcher made appointments to interview participants at their convenience. CHPs were interviewed by talking to one nurse at a time. They were visited in the afternoon when the facility was not full and they were not too busy, and, any available CHP was interviewed as need be.

THPs were requested to come to a central point and those who could not were visited either in their homes or invited to other appropriate settings. Respective appointments were made according to proximity of THPs to each other or an identified central point. Results for all participants were analysed and interpreted according to themes and sub-themes respectively and not according to FGDs and individual groups because their representativity and interpretation were the same.

## **4.2 PRESENTATION OF THE FINDINGS**

The following four themes with sub-themes were identified during data analysis. These emerged themes were general understanding and feeling about the partnership, benefits, referral system and challenges relating to a partnership between THPs and conventional health care systems.

### **4.2.1 General understanding and feeling about the partnership**

#### **Traditional Health Practitioners**

The findings of the study revealed that the THPs participating in the study had a good understanding of the partnership. This is demonstrated in the excerpts below:

*“We are aware and understand the partnership we have with the clinics since we meet on a monthly basis.” [FGD 1, THP 6]*

*“As THPs we hold meetings with nurses on a monthly basis.” [FGD 2 and THP 2]*

However, most THPs reported that in spite of the understanding they had about partnership, they still experienced a lack of support from the government. The government seemed not to acknowledge the THPs. This is clearly indicated in the quote below:

*“The government is not supporting us in any other form like funding, subsidies in any form, access to health admitting institutions or facilities to support our clients by either burning incense, giving traditional drinking ‘muthi’ like ‘imbiza’ whilst patient is admitted.” [FGD 1]*

In the interviews THPs expressed a broad understanding about the partnership and they said they felt that the government is dragging the process of officialising working together and is not readily buying in or coming fully on board as they would wish.

*“...The government is slow and dragging to fulfil this partnership process...” [FGD 1, THP 1]*

Most participants stated that the government or government employees undermine them and their practices. Some of the many causes of being undermined were their low level of education, walking on bare feet, some level of uncleanness especially those who use snuff.

*“Conventional health care practitioners look down upon us because they say we have low educational level and we walk on bare feet” [THP 15]*

Almost all participants responded that they prefer to first refer their clients to the conventional health care system to be medically checked, diagnosed and treated so that they can then start their traditional treatment. This they said is due to the

knowledge they have about the conventional interventions and working together in order to get their clients treated comprehensively. This is reflected below:

*“We prefer to first refer our clients to the clinic to be checked, diagnosed and treated conventionally before we can use our traditional medicine. We know when to refer and how to talk to them regarding medical check-ups so that we could start our traditional treatment thereafter”* [FGD 2, THP 1]

Some THPs gave testimonies about themselves. For example, they were on ARVs because they were screened at the conventional health centre which the THPs cannot do. This is supported hereunder:

*“...We are well on ARVs because we received this type of help from the clinic and not from our traditional ‘muthi’.”* [FGD 1]

### Conventional Health Practitioners

In one facility that has both provincial and local government employees located under one roof, a provincial member of staff stated that they did not know anything about a partnership happening in that facility and denied having meetings with the traditional practitioners. This is reflected in the excerpt below:

*“...I would know and would have been part of such meetings if there were any. There is no partnership happening in this facility....”* [CHP 3]

Some conventional health practitioners stated that they were aware that clinics work with THPs but that was not practised actively as they were not even having meetings with the traditional practitioners to discuss health issues for the specific area. This is confirmed below:

*“Yes we are aware that we are working together with the THPs but the system is not that active.”* [CHP 7]



One facility stated that they invite THPs to their events and provide them with their own stand or stall for marketing and advertisement. They refer clients for 'ukuhlola' if they wish and THPs refer them back immediately in the same event.

*"We have an active system in place. We attend meetings together if need be. We communicate every now and then as per need."* [CHP 1]

*"We have a solid clinic committee that involves THP members as well."* [CHP 8]

*"We invite THPs to our meetings and we also meet with them in the war room meetings for the "Sukuma sakhe programme."* [CHP 1]

*"We meet with the local THPs when they have their own meetings, if there is a need."* [CHP 8]

The majority of the participants responded that they understood the partnership and were happy to finally be able to work together even though there were still some challenges. They further reported that because of the referral system they have in place, they were able to manage clients holistically. This is demonstrated below:

*"...Now clients come to the clinic with referral forms from the THPs without any fear or shame and we are able to assist them to take both our medication successfully."* [CHP 2]

The participants voiced their feelings of uncertainty with the departmental support in terms of taking the partnership to a higher level. This is reflected below:

*"We last had in-service or training by the Professor from the University few years ago and we have not received any other update or training of those who missed previous training or have any written guidelines as a way*

*forward and improvement in strengthening the partnership with the THPs.”*  
[CHP 6]

*“.....However, we trust and hope that we will have a successful relationship and client care in future. THPs are a valuable support system in the health care services given the current health status we have in our country. We could utilize them as DOT supporters, counsellors, family support system or otherwise, given an enabling environment.”* [CHP 5]

#### **4.2.1.1 Progress in partnership**

##### Traditional Health Practitioners

Some THPs responded that the government was not taking this partnership seriously. They stated that they felt the process was taking too long to be officially implemented, as indicated below.

*“...The government is slow and dragging to fulfil this partnership process...”* [THP 11]

##### Conventional Health Practitioners

Some participants stated that in their area, the progress is fairly on the right track. However, they were doing this on their own without any directive or support. This is reflected in the quotes below:

*“We work well with the THPs in our local area and as a result we hold meetings and events together and our referral system is working well.”*  
[CHP 1]

*“The Department of health directive has not yet given us any guidelines or support to smoothly run with the partnership especially when it comes to taking medication.”* [CHP 2]

#### 4.2.1.2 Platform to discuss health issues

##### Traditional Health Practitioners

Some respondents stated that they did not hold formal meetings as stakeholders for health both at community and clinic level.

*“We do not hold local meetings with the conventional sector to discuss our clients’ health related issues”. [FGD1]*

All respondents reported that they did not discuss health issues but other local area issues, even when they had meetings.

*“We do not discuss health matters in our clinics or local meetings.” [FGD 1, THP 6] and FGD 2, THP 1]*

##### Conventional Health Practitioners

Participants responded that they had not really discussed health issues with their counterparts even when they met, which was rarely the case. This is supported by the following excerpt:

*“.....We seldom have meetings with the THPs and even when we do, we have not discussed minor ailments or diseases that affect our community.” [FGD 1, THP 1]*

*“Meetings that we have had have always been organised by either the clinic or the THPs separately, that automatically makes the organisers draw up their own agenda without involving the counterpart.” [THP 10]*

*“We have never sat together to plan to have a meeting and therefore draw up a joint agenda that could accommodate both our interests for discussion.” [FGD 1]*

#### 4.2.1.3 Consultation

##### Traditional Health Practitioners

During interviews it was revealed that participants did not get consultation as they would prefer because they were mostly told of the decision already taken by the government.

*“The government tells us what to do without us being part of the discussions and therefore decision making.”* [FGD 2, THPs 1 & 6]

All participants stated that the Act 22 of 2007 was passed without them being part of the discussions and yet it was about them. This is supported by the following quote:

*“...The government cannot approve the act about us without consulting us....”* [FGD 2, THPs 2 & 9]

##### Conventional Health Practitioners

Some participants said that this was thrown at them without any explanation. They had to learn how to deal with the situation along the way. However, they said that they understood the need. This is supported by the following quote:

*“...Sometimes we have a problem in explaining how the client must take both traditional and conventional medicine because no one ever told us how this should happen...”* [CHP 7]

*“In the medical field there are guiding policies, protocols and procedure manuals that govern implementation of procedures but there is nothing for combining both Traditional and conventional medicine....”* [CHP 6]

## **4.2.2 Benefits of the partnership**

### **4.2.2.1 Beneficiaries of the partnership between African traditional and conventional health care**

#### Traditional Health Practitioners

Participants responded that the government had benefitted them in many ways by educating them in health related issues. For example most of them had done HIV counselling and TB health information training. They further reported that they could tell if a client was not well at all and probably needed urgent attention. All the health information they received from the government helped them to identify what they could treat and what they could not. Therefore they referred these clients accordingly. They further argued that they were also able to provide those who needed emotional, psychological, spiritual and physical support. In some instances they provided DOT support; hence the government's revival of the DOT strategy, especially in the TB programme. This was expressed by participants in the following quote:

*“The government has taught us about many medical conditions. Now we know what to do when and how in order to support our clients in every possible way, be it physical, spiritual, psychological, emotional or even financial.”* [FGD 2, THP 3]

*“This in turn helps everybody involved in the client care as the client gets attended to comprehensively at the community level where we closely live with them.”* [FGD 2, THP 9]

## Conventional Health Practitioners

Conventional health care practitioner said they benefit from the partnership by not losing clients in the process of treatment by both practitioners. The following quote illustrate their views:

*“We no longer lose our clients to the traditional practitioners.”* [CHP 8]

The participants from one facility reported that they had gained trust and understanding from their counterpart such that when they attended special events together. Whoever wanted to consult either with the THPs or conventional health practitioners did so with easy access and were easily referred back to them immediately. This is demonstrated in the following quote:

*“When we have events, we invite THPs to have their own stand for consultation on site.”* [CHP 1]

It emerged from conventional practitioners that clients now come early to the clinics for screening of any condition, especially HIV and TB. As stated below:

*“We now get clients in the early stages of their diseases.”* [CHP 2]

Participants received testimonies from clients that they also use THPs as their psychologists and DOT supporters because even when they are diagnosed with HIV they come back to the THPs with the results for a comprehensive support system. This is shown in the quote below:

*“Clients have trust in THPs....”* [CHP 1]

Participants also stated that this partnership helps the department of health with the indicators in reducing defaulter rate and promoting adherence. Below is the confirmation of the outcomes:

*“Adherence and defaulter rate improves where THPs are involved.”* [CHP 9]

#### **4.2.2.2 Training in health matters**

##### Traditional Health Practitioners

Most THPs responded that the government has helped them by training them on health related issues. This is reflected in the excerpts below.

*“We have learnt HIV counselling, TB signs and symptoms and therefore are now able to refer clients to the clinic with insight”. [FGD 1, THP 4, THP]*

##### Conventional Health Practitioners

According the interviews conducted, conventional health care practitioners revealed that they had not had adequate training in traditional medicine. This is reflected below.

*“We did not attend any traditional practice training.” [CHP 4]*

Only a few conventional health practitioners admitted that they were trained as reflected below:

*“We did attend training in a local university that was facilitated by a professor on traditional medicine.” [CHP 3]*

#### **4.2.3 Referral system**

##### Traditional Health Practitioners

The participants responded that they had sound knowledge about the referral system. However, they voiced their concerns about the conventional health care sector that were not referring patients back to them as indicated in the excerpts below:

*“We do have the referral forms and we refer our clients to the conventional practitioners but they do not refer the patients to us. Even if we have*

*referred patients to them, they are never referred back to us” [FGD1, THP 7]*

THPs said that they should be getting acknowledgement receipts detached from the bottom of the referral letter from the conventional partners as a referral back to the THPs, as shown below.”

*“Acknowledgement of receipt of referral letter is happening at a very slow pace or low rate to a point that it is almost not happening”. [THP 12]*

### Conventional Health Practitioners

Most participants responded that they had never received any form of referral letters from the THP, as reflected below:

*“We do not receive any referral letter from the THPs.” [CHP 5]*

Some respondents stated that they were aware of the referral system but it was not well practised by both practitioners. Below is the demonstration of that poor referral system:

*“We do work together and we know about the referral system. However, it is not that active as we only receive very few referral letters from the THPs considering the number of THPs we have in eThekweni and the assumed number of clients who consult THPs.” [CHP 6]*

In one clinic, the conventional health practitioners reported that they invited THPs to their events and provided them with their own stand or stalls and they referred clients for *ukuhlola / prophesied* if they wanted to and THPs referred them back immediately in the same event. Participants from this clinic responded that they had a good referral system with standardised referral forms in use, as quoted below:

*“We have our active referral system in place.” [CHP 2]*



#### 4.2.4 Challenges regarding partnership

Although the participants reported the benefits of the partnership between THPs and conventional health care, they also highlighted the challenges that they were faced with and these are discussed below:

##### Traditional Health Practitioners

Participants responded that they were not content with the nature of the partnership between different practitioners. They were of the opinion that they were not on the same level as their counterpart in terms of categorization, respect and classification. This is reflected below:

*“Conventional health practitioners take us as community care givers. They want us to go door to door and care for the sick in their homes. This is not our job. We are doctors and clients come to us and not the other way round.”* [FGD 2, THP 1]

*“We are happy to work with the government but at the moment it seems like we do not have a common goal and we seem to be the only ones doing the partnership and not the government partnering with us.”* [FGD, THP 5]

The participants responded that they understood themselves as doctors in their capacity and should be treated as such. They were also not happy about the fact that they were expected to refer clients to the clinic and the clinics did not refer to them, not to mention a lack of acknowledgement. This is demonstrated in the quote below:

*“The government wants us to take or refer clients to the clinics and not the conventional health practitioners refer or bring clients back to us the THPs.”* [FGD 2, THP 2]

*“The government treat us as if we are the only ones who want to work with the conventional practitioners and not them wanting to work with us.” [THP 6]*

#### Conventional Health practitioners

The majority of the participants reported that they have not benefited much from the referral system between THPs and conventional health practitioners. Their responses regarding the referral system are indicated in the excerpts below:

*“We have not had many benefits from this partnership...” [CHP 6]*

*“We only get indirect benefit of getting clients referred and coming early to the clinic.” [CHP 5]*

*“THPs acknowledge the fact that conventional medicine cannot be replaced by traditional medicine as some THPs are on ARVs because traditional medicine could not help them.” [CHP 7]*

*“We do not see as many clients with referral letters from THPs as we would wish....” [CHP 6]*

Participants stated that the systems currently in place were not user friendly to allow them to work jointly in all aspects like taking medication. They reported that they did not have a clear guide of how to take both conventional and traditional medicine simultaneously. This is reflected in the quote below:

*“Generally, at the moment we do not have any clear guidelines or protocols that guide us on how to function with THPs especially when it comes to giving medication.” [CHP 7]*

The participants responded that they were content that THPs were trained in western medical health issues. However, conventional health care providers reported that they had not been trained in traditional medicine. Their concerns are reflected below:

*“THPs have been trained in conventional medicine but few of us have been trained in traditional medicine....As a result, we do not understand how they work.”* [CHP 6]

*“In our nurse training, we were never introduced to the Traditional health care practices. We have identified this as a shortfall in the nurses’ curriculum.”*

[CHP 4]

### 4.3 SUMMARY OF THEMES

The table below provides a summary of themes that emerged from analysis of data as discussed above.

Table 4.1: Summary of themes

Themes	Sub-themes
1. General understanding and feeling about the partnership	A. Platform to discuss health issues B. Progress in partnership C. Consultation
2. Benefits	A. Beneficiaries B. Training on health matters
3. Referral system	A. Standardised referral letter
4. Challenges regarding the partnership between THPs and conventional health care	A. Positive reaction B. Challenges

#### **4.4 CONCLUSION**

This chapter presented the results of the study conducted to explore the collaboration between traditional and conventional health care practitioners. Results were analysed and tabled according to themes and sub-themes categorically. Findings were given with THPs separate from conventional health care practitioners comparatively.

##### Traditional Health Practitioners

Participants were generally not happy with the way the system currently works, they did not like the fact that the conventional health practitioners did not refer clients to them but THPs refer them. They also did not like the fact that collaboration did not benefit them individually in the form of incentives like money, subsidies to, for example, legally and officially get their herbs from the big forests, transportation to the clinics or any training and meeting venue. They are however happy about the trainings they had although they would have loved to have every THP undergoing the trainings as some of them did not attend any trainings. Collaboration seemed to be one sided from the THPs only and without any correspondence from the conventional practitioners.

##### Conventional practitioners

Participants were satisfied with the referral of clients by the THPs to the conventional health practitioners. However, the conventional health practitioners had difficulty in referring back to the THPs as they did not have any supporting policies, protocols or referral letters from them to the THPs. They were able to respond to the THPs referral letter by detaching the acknowledgment receive and give it back to the client to take back to the referring THP. They also did not have experience, training, knowledge or understanding of traditional health practices that they could refer to when attending to clients referred by THPs. The few that underwent some traditional medicine practices did not have impact on

collaboration as a result they were open to have more traditional medicine trainings if opportunities come.

## **CHAPTER 5**

### **DISCUSSION OF RESULTS**

#### **5.1 INTRODUCTION**

In the previous chapter, the research results were presented and this chapter focuses on the discussion of the results. The discussion of the results is guided by the aim and objectives of the study as described in the first chapter, as well as the themes that emerged from the analysis of the interviews.

#### **5.2 DISCUSSION OF THE RESULTS**

Interviews with the participants of all categories according to the inclusion criteria were conducted to explore the nature of the partnership between traditional and conventional health care in the eThekweni District. The findings of this study revealed that the majority of the THPs had a common feeling about conventional medicine and the way that the government responds to their needs. They reported that the government did not really care about them, but is only concerned about using them to help where needed. On the other hand, the conventional health practitioners verbalised that they had their own concerns about some of the THPs' practices.

This chapter is discussed under the following headings:

- General understanding and feeling about the partnership
- Benefits
- Referral system
- Challenges regarding partnership between THPs and conventional health care

### **5.2.1 General understanding and feeling about the partnership**

The results of this study revealed that the THPs and conventional health practitioners embrace the idea of partnership although both practitioners reported some challenges related to the partnership. The Traditional Health Practitioners Act 22 of 2007 (Republic of South Africa, 2007) suggests that the South African government is in the process of incorporating and integrating traditional health systems, making every medical practitioner to form part of the traditional/conventional medical society that works together and understand both health care systems. Psycho-socio-cultural background plays an integral and vital role in one's life orientation and mind shaping. Integrating two practices with totally different background is obviously challenging for everyone involved in the implementation process, be it the practitioners themselves or consumers who are the end users and beneficiaries of service delivery.

The fact that THPs have not really been incorporated into the District Health System (DHS) led to the partnership not being fully accepted and implemented by both parties involved. The THPs are of the opinion that they will have a better platform once the statutory council has been established where they will conduct discussions on an equal footing (Pretorius, 1998). The government has made some progress in legitimising traditional medicine. This is supported by the setup of a statutory council by the SA parliament to regulate the 350 000 THPs available in every 200 or 300 members of the population served (Baleta, 2004).

The findings of this study showed that the conventional health practitioners were hesitant in forming partnership with other health care providers. However, they were willing to have THPs on board.. This is evident when, even during this era, there is still inadequate clinician experience combining herbal, traditional or complementary medicine with antiretroviral therapy (ARVs) in South Africa (Department of Health, 2009). Conventional practitioners tend to detach from the cultural background of their clients and that leads to incongruent health care

provision. This is supported by De Villiers (2006), where he explains that members of a culture share a worldview which is a product of the context in which they were raised. This therefore suggested that health care practitioners could work harmoniously and productively if they understand the culture and the background of the end users of their products (De Villiers, 2006).

### **5.2.2 Benefits**

The findings of this study revealed that the collaboration could have some benefits that favour mostly THPs and the government. The government is in a good position to take advantage of this emerging trust between the THPs and their clients because they could utilize THPs as DOT supporters. The WHO is reviving the DOT strategy to improve TB indicators worldwide. Clients get an opportunity to be treated traditionally and medically, but they are always taught to first treat their medical conditions and follow up with the traditional ones. This helps the DoH with their indicators in reducing default rate and promoting adherence. It also brings stability within the community and therefore a psychologically and mentally sound society.

HIV is one common factor that links THPs to the conventional health practitioners. THPs are expensive to consult compared to conventional health care, where ARVs are free of charge and work even better than traditional medicine. Based on the findings of this study, this partnership benefits patients as they get to be seen by more than one practitioner and get referred accordingly. Even when they are diagnosed HIV positive and are put on TB drugs from the clinic, they still come back to seek THPs opinion (Integrated Regional Information Network, 2011).

Generally, THPs felt that the government has benefitted them in many ways by educating them in health related issues. e. g. most of them have done HIV



counselling; TB health information training or they can see if a client is not well at all and probably needs urgent attention. All the health information they get from the government helps them to identify what they can treat and what they cannot and therefore act accordingly. They are also able to provide for those who need emotional, psychological, spiritual and physical support. In some instances they provide DOT support. Hence the government's revival of DOT strategy especially in the TB programmes. Because of the THPs' involvement and trust in the community, in 1974 after the Geneva conference, the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), recommended that traditional medical practitioners and traditional birth attendants be trained in PHC (WHO, 2010).

The operational plan for comprehensive HIV and AIDS care, management and treatment for South Africa recognizes the role and function of traditional practitioners in the continuum of care, compliance, adherence, adverse event reporting, referral system and ensuring safe traditional health practices (Department of Health, 2004). This helps the department in achieving the targeted goals. Conventional practitioners believe that having THPs as partners brings stability within the community and therefore a psychologically and mentally sound society. Generally, when clients consult THPs they do not associate them with western health information, but rather the spiritual world. Disease patterns, times and globalization have changed such stereotypical mind set and situations. They are always taught to first treat their medical conditions and follow up with the traditional ones.

The government is in a good position to take advantage of this trust between the THPs and their clients because they could utilize THPs as DOT supporters in eThekweni. It is already happening in some parts of KZN where THPs are being utilized as DOT supporters (Colvin as cited by Peltzer, Mngqundaniso, and Petros, 2006). The WHO is reviving the DOT strategy to improve TB indicators

worldwide. Clients get an opportunity to be treated traditionally and medically, but they are always taught to first treat their medical conditions and follow up with the traditional ones (Colvin, Gumede, Grimwade, Maher, and Wilkinson 2002).

With regards to training generally, THPs have benefitted from the partnership in many ways. They were trained in health related issues. For example, most of them have acquired HIV counselling skills, TB health information training to recognize other signs and symptoms training of other diseases like diabetes and dehydration in children with diarrhoea. This is benefiting them in one way or another by making them confident and competent when managing their clients. They can see if a client is not well enough and needs urgent medical attention. All the health information they received from the government helped them identify what they could or could not treat and therefore refer accordingly. They were also able to provide for those who needed emotional, psychological, spiritual and physical support.

### **5.2.3 Referral system**

The THPs were clear about the reasons for referral as well as initiating TB and HIV talks, like testing at the clinic before starting their own treatment especially if one was very sick or had “*amagobongo*” (ancestral spirits that demand some ritual to be performed to an individual). This was supported by the study done by Peltzer, Mngqundaniso, and Petros (2006a) in Hlabisa where he found that more than half of the THPs were involved in HIV management in terms of assessment, referral for HIV testing, STI partner referral and home visits. The reason for testing when one had *amagobongo* was because they believed that HIV brought up every sickness from one’s body because the ancestors were usually angry because they saw that the person was sick and could not provide them with what they wanted from him or her. For that reason they preferred to first refer the client to the conventional health care system to be medically treated so that they could then start their traditional treatment (Peltzer, Mngqundaniso, and Petros, 2006b)

There were well developed referral forms written in local language in place, at that time. These were for the THPs to refer to their conventional partners and get an acknowledgement of receipt detached from the bottom of the referral letter. So far referral had only been done by the THPs to the conventional health care and reversal had not been happening. However, acknowledgement of receipt of referral letters had been happening (SAMA, 2006). Sometimes clients would not show their referral letters to the conventional practitioners and therefore the staff would not know if the client had attended THPs and an acknowledgement of receipt would also not be available thereof. Clients complained about the unpleasant attitudes of the conventional staff that made them not to feel free to produce their referral letters. They stated that nurses scold at them and that made them scared to explain most things including their visits to THPs. They felt that sometimes it was not easy to work hand in hand with the THPs, it was okay to receive referral letters from them and work on them, but to refer back to the THPs was still a challenge.

According to the medical field, there should be guiding policies, protocols and procedure manuals that govern implementation of procedures. That is not available in the THP arena and there were no written books or references that guided traditional health practices. This made it difficult to work with them as they were only guided by their only intuitive directives.

The findings of this study revealed that most conventional practitioners supported partnership with the THPs. They welcomed and consulted referred clients from THPs with open arms and gladly refer them back to the THPs using the same referral letter they came with. Generally, the conventional practitioners were interested in the THPs referring clients to them and not the other way round. However, some welcome collaboration. Most of them did not really understand traditional health practices, so they were sceptical in this collaboration. The fact that there is inadequate clinician experience combining herbal, traditional or

complementary medicine with ARVs (Department of Health, 2009) suggested that conventional practitioners could not fully account for traditional health practices. Some were active, all on board and attended all health meetings together. One facility invited THPs to their events and provided them with their own stand or stall for marketing and advertisement. They referred clients for “*ukuhlola*” (checking up or prophesying their personal lives) if they so wished and THPs referred them back immediately in the same event.

### **5.3 CHALLENGES REGARDING THE PARTNERSHIP BETWEEN TRADITIONAL HEALTH PRACTITIONERS AND CONVENTIONAL HEALTH CARE**

The results of this study revealed that THPs were receptive and flexible in working with conventional health care providers. This is evidenced in the SAMA (2006) that THPs were even willing to make certain concessions for the sake of co-operation. However, they had their concerns. They were dissatisfied with the manner in which the partnership was taking place. The fact that they were not on the same level in terms of categorization, respect and classification made them to want to discuss this partnership even further. They reported that there was no specific formal job description from the Department of Health for THPs to enable them to function. However, conventional health practitioners expected THPs to act as community care givers as well. In their meeting, they shared their feelings that the government wanted them to go door to door and care for the sick in their homes. They were of the opinion that this did not form part of their job, as they were referred to as doctors.

They stated that they were doctors in their capacity and should be treated as such; otherwise they felt belittled and undermined. This was partly because traditional healing is based on a perceived aetiology originating predominantly in the social and supernatural sphere and not from academia. Conventional graduates did not understand the qualifications, respect and value of the THPs

(SAMA, 2006). They were also not happy with the fact that they were expected to refer clients to the clinics and the clinics did not refer them back to them, not to mention lack of acknowledgement. This was putting some strain especially on the willing party and was discouraging and in turn it hindered the partnership process. The government was treating THPs as if they were the only ones who wanted partnership and not the government. This did not sit well with THPs as they used their ancestral acquired powers to treat clients and nothing from the government.

The findings of this study also showed that there was lack of enthusiasm from the conventional practitioners about the partnership. They were somehow bound to the principle of THPs bringing their clients to them and not the other way round. Most conventional health care practitioners were not trained in and had got no idea about traditional medicine to an extent that they were unlike Africans. They reported that they did not have an interest in learning about traditional health practices. Even though facilities did not have full engagement in collaboration, however, one facility reported that there was active involvement and partnership with the THPs. Most conventional practitioners tend to associate traditional healing with myth and magic and 'primitive' culture that uses non-scientific techniques (SAMA, 2006).

## **5.4 CONCLUSION**

The findings of this study revealed that in eThekweni Different types of THPs are accessible in. Currently, both parties work in silos except for a few facilities that do work with THPs but even they themselves not fully collaborated in all health care functioning aspects. Those that do work together only do so to meet the needs of the facilities and not of the THPs and THPs are not happy about that. On the other hand conventional health practitioners are sceptical about traditional health practices as they do not have references and background about traditional health practices. The eThekweni district needs THPs as available human

resource and to utilize them to fight ill-health, poverty and community based anomalies. Collaboration is currently disadvantaged mainly by a lack of supporting of each other. It could form the basis of improving communities' lives if there could be open consultation, training, addressing challenges and cooperation from all parties involved, including the government. EThekwini THPs are not fully and objectively utilized according to the communities' health needs and large numbers. Government could turn this around if they could take the lead in the partnership programme.

## **5.5 RECOMMENDATIONS**

The following recommendations are based on the findings of the study. These address policy development and implementation, education of health care providers and further research. Below are the recommended topics to pay attention to:

- Policy development and implementation that will guide all health implementers
- Institutional management and practice especially for recording and reporting
- Education and training for empowering health care professionals
  - Nursing training
  - Medical training
  - Further research

### **5.5.1 Policy development and implementation**

The traditional and conventional health care providers that all THPs should be registered in their respective associations by a board of registration and be known in order to strengthen collaboration and to prevent charlatans from engaging in malpractices and abusing their positions and clients.

It would take the collaboration to a higher level and strengthen it if the government could be actively involved in supporting and facilitating facilities and play an active role in fast tracking policy and implementation of the Traditional Health Practitioners Act. The THPs executive committee are now part of the policy making discussions, if both THPs and the government could reach some form of memorandum of understanding there could be a way forward in the implementation of those policies. This could help to bring both parties to work together effectively and harmoniously.

### **5.5.2 Institutional management and practice**

It is also recommended that DoH should consider adding some data elements that pertain to, for example, the number of clients seen by the THPs, specific conditions treated, number referred to the conventional health care practitioners and number referred back to the THPs by the conventional practitioners on the District Health Information System (DHIS). MDGs could be approached from the Public Private Partnership (PPP) or Public Private Mix (PPM) angle in order to help achieve them. THPs should be allowed to treat their clients in a conventional health institution without prejudice and this should happen in a harmonious manner that will not disrupt institutional routine. If this could be implemented there should be clear and precise guidelines to regulate use of traditional medicine especially within the health facilities.

### **5.5.3 Education and training**

Traditional health medicine should be incorporated into the conventional training of nursing students of any category. This should be included in the curriculum of nursing for all nursing qualifications. Preferably this should be done in later years of study or towards the end of their studies in order to correlate theory and practica with understanding than when students are still new in the medical field with very little knowledge of how to implement theory and practica cognitively.

Traditional medicine is already included in some medical schools of South Africa for example, at Nelson Mandela School of Medicine and at Walter Sisulu Universities. This is rightfully done in the third year level of medical training when students can correlate theory to practical with understanding. Another recommendation is that all South African medical schools add traditional medicine to their curriculum, and preferably in the latter years of training. This could help the medical students when they have qualified, to understand the traditions, culture, values, and norms of the community they serve. This will add to and improve on the partnership that has already started to take it to a higher level.

#### **5.5.4 Further research**

The THPs reported that conventional practitioners are secretive regarding their diagnostic methods and remedies. Further research needs to be done in the field of traditional medicine and traditional practices of all aspects. Research could be done in initiation of traditional medical students; starting to work post initiation; safety and efficacy of traditional medicinal drugs; mixing or taking both traditional and conventional medicine concurrently.



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Yin, K. 2009. *Case Study Research Design and Methods*. 4<sup>th</sup> Ed. London: Sage

### ETHICS CLEARANCE CERTIFICATE

Student Name	Busisiwe Edith Nzimande	Student No	20812889
Ethics Reference Number	001/11	Date of FRC Approval	7-02-2011
Qualification	M Tech: Nursing		
Research Title	Exploration of the partnership between African traditional – and conventional health care in eThekweni District		

In terms of the ethical considerations for the conduct of research in the Faculty of Health Sciences, Durban University of Technology, this proposal meets with Institutional requirements and confirms the following ethical obligations:

1. The researcher has read and understood the research ethics policy and procedures as endorsed by the Durban University of Technology, has sufficiently answered all questions pertaining to ethics in the DUT 186 and agrees to comply with them.
2. The researcher will report any serious adverse events pertaining to the research to the Faculty of Health Sciences Research Ethics Committee.
3. The researcher will submit any major additions or changes to the research proposal after approval has been granted to the Faculty of Health Sciences Research Committee for consideration.
4. The researcher, with the supervisor and co-researchers will take full responsibility in ensuring that the protocol is adhered to.
5. **The following section must be completed if the research involves human participants:**

	YES	NO	N/A
❖ Provision has been made to obtain informed consent of the participants	X		
❖ Potential psychological and physical risks have been considered and minimised	X		
❖ Provision has been made to avoid undue intrusion with regard to participants and community	X		
❖ Rights of participants will be safe-guarded in relation to:	X		
- Measures for the protection of anonymity and the maintenance of Confidentiality.			
- Access to research information and findings.	X		
- Termination of involvement without compromise	X		
- Misleading promises regarding benefits of the research	X		

SIGNATURE OF STUDENT/RESEARCHER

11/02/2011  
DATE

SIGNATURE OF SUPERVISOR/S

11/02/2011  
DATE

SIGNATURE OF HEAD OF DEPARTMENT

11.02.2011  
DATE

SIGNATURE CHAIRPERSON OF RESEARCH ETHICS COMMITTEE

15/02/2011  
DATE

Er Dean Acting



## **Appendix 2: Letter of Permission to eThekwini District**

The District Manager  
Ms S. G. R. Shezi  
EThekwini District Office  
83 King Cetshwayo Highway  
Highway House  
Mayville  
4380

Dear Madam

### **Re: Request for permission to collect data from eThekwini District health facilities for a Research Project.**

I am a student in Masters Degree Program at Durban University of Technology in the Department of Community Health Studies, Nursing Programme. I am expected to conduct a research project as one of the requirements that will lead to the completion of my degree program. My research project title is: **“A case study exploring the nature of partnership between African traditional and conventional health care in eThekwini District”**.

Having obtained ethics approval from the Research Ethics Committee, Durban University of Technology, Faculty of Health Sciences, I hereby seek your permission to be able to proceed to collecting data from eThekwini health facilities. I assure you that data collected will only be used for the purpose of this study and all ethical requirements regarding participants in research study will be adhered to and I will endeavor to keep within the routine of the clinic without disrupting the flow of service to clients.

Attached is a copy of my research proposal and the relevant documents indicating how the whole process will be carried out as well as the informed consent document and information sheet addressed to the participants to be involved in this study.

Looking forward to hearing from you on the above request and thanking you for your kind attention to this matter.

Yours sincerely

B. Nzimande (M Tech student)

[Busi.Nzimande@kznhealth.gov.za](mailto:Busi.Nzimande@kznhealth.gov.za) (Email)

082 688 9113 (Cell)

031 240 5436 (Tel)

031 240 5446 (Fax)

Dr MN Sibiya (Supervisor)

[nokuthulas@dut.ac.za](mailto:nokuthulas@dut.ac.za) (Email)

031-373 2032 (Tel)

Prof N Gqaleni (Co-Supervisor)

[gqalenin@ukzn.ac.za](mailto:gqalenin@ukzn.ac.za) (Email)

031-260 4280 (Tel)



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Email.: [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)

[www.kznhealth.gov.za](http://www.kznhealth.gov.za)

Reference : HRKM40/11  
Enquiries : Mrs G Khumalo  
Telephone : 033 – 3953189

Dear Ms B E Nzimande

22 March 2011

**Subject: Approval of a Research Proposal**

1. The research proposal titled 'Exploration of the nature of partnership between African traditional and conventional health care in eThekwin' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at selected clinics at eThekwin district.

2. You are requested to take note of the following:
  - a. Make the necessary arrangement with the identified facility before commencing with your research project.
  - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely

  
Mrs E Snyman

Interim Chairperson, Health Research Committee

KwaZulu-Natal Department of Health

Date: 25/03/2011

uMnyango Wezempilo . Departement van Gesondheid

*Fighting Disease, Fighting Poverty, Giving Hope*

#### **Appendix 4: Letter of Permission to eThekwini Local Government Manager**

The Manager  
Dr T Ngomane  
EThekwini Metro Health  
Archie Gumede Place  
Durban  
4000

Dear Madam

**Re: Request for permission to collect data from eThekwini District health facilities for a Research Project.**

I am a student in Masters Degree Program at Durban University of Technology in the Department of Community Health Studies, Nursing Programme. I am expected to conduct a research project as one of the requirements that will lead to the completion of my degree program. My research project title is: **“A case study exploring the nature of partnership between African traditional and conventional health care in eThekwini District”**.

Having obtained ethics approval from the Research Ethics Committee, Durban University of Technology, Faculty of Health Sciences, I hereby seek your permission to be able to proceed to collecting data from eThekwini health facilities. I assure you that data collected will only be used for the purpose of this study and all ethical requirements regarding participants in research study will be adhered to and I will endeavor to keep within the routine of the clinic without disrupting the flow of service to clients.

Attached is a copy of my research proposal and the relevant documents indicating how the whole process will be carried out as well as the informed consent document and information sheet addressed to the participants to be involved in this study.

Looking forward to hearing from you on the above request and thanking you for your kind attention to this matter.

Yours sincerely

B. Nzimande (M Tech student)

[Busi.Nzimande@kznhealth.gov.za](mailto:Busi.Nzimande@kznhealth.gov.za) (Email)

082 688 9113 (Cell)

031 240 5436 (Tel)

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Dr MN Sibiya (Supervisor)

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031-373 2032 (Tel)

Prof N Gqaleni (Co-Supervisor)

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031-260 4280 (Tel)



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Deputy Head: Clinical Support Services

Dr N. Ngomane

Telephone 031-3113539

20 July 2011

B. Nzimande

MTech Student

Dear Miss Nzimande,

**RE: Collection of data from eThekweni District Health facilities**

Approval has been granted for you to collect clinical data from the following facilities Cato Manor CHC, Chesterville, Lamontville.

Prior arrangements must be made with the following Operational Managers before going to the facilities:

Cato Manor	Mrs N. Luthuli	031-2644260
Chesterville	Mrs N.V. Shangase	031-2640090
Lamontville	Mrs F.A. Tsekitso	031 4692366

Yours faithfully

Dr N. Ngomane

Deputy Head: Clinical Support Services

## **Appendix 6a: Letter of Information and Consent**

**Title of the Research Study:** “A case study exploring the nature of partnership between African traditional and conventional health care in eThekweni District”

**Principle Investigator/s:** Ms. B. E. Nzimande

**Supervisor:** Dr MN Sibiyi

**Co-Supervisor:** Prof N Gqaleni

**Brief Introduction and Purpose of the Study:** This study seeks to look at the nature of partnership between African traditional and conventional health care in eThekweni District

**Outline of the Procedures:** You are kindly requested to respond to questions that I am going to ask you. Our conversation will be audio-recorded

**Risks or Discomforts to the Subject:** There are no risks involved in this study.

**Benefits:** This study seeks to ensure continuity of care that is given to patients.

**Reason/s why the Subject May Be Withdrawn from the Study:** You are advised to withdraw from the study if you feel uncomfortable or for any other reason that may deem them unfit to do or continue with the study

**Remuneration:** None

**Costs of the Study:** None

**Confidentiality:** Your name and identity will not be disclosed in this study. The informed consent with your name will be kept separately from the interview guide.

**Research-related Injury:** None

**Persons to Contact in the Event of Any Problems or Queries:** Dr Sibiya (Supervisor) at 031-373 2032 and Prof Gqaleni (Co-Supervisor) at 031-260 4280.

**Statement of Agreement to Participate in the Research Study:**

(I,.....subject's full name,  
ID number....., have read this document in its  
entirety and understand its contents. Where I have had any questions or queries,  
these have been explained to me by Ms Busisiwe Nzimande to my satisfaction.  
Furthermore, I fully understand that I may withdraw from this study at any stage  
without any adverse consequences and my future health care will not be  
compromised. I, therefore, voluntarily agree to participate in this study.

Subject's name (print) .....

Subject's signature:..... Date:.....

Researcher's name (print): Ms Busisiwe Nzimande

Researcher's signature:.....Date:.....

Witness name (print):.....

Witness signature:.....Date:.....

Supervisor's name (print): Dr MN Sibiya and Prof Gqaleni (Co-Supervisor)

Supervisor's signature:.....Date:.....

Co-Supervisor's signature:.....Date:.....

---



**Isengezo 6b:** Incwadi yolwazi nemvume

**Isihloko socwaningo:** Ucwaningo ngobudlelwane phakathi kokunakekelwa kwempilo ngendlela yesintu kanye nangendlela yesilungu esiyingini saseThekwini

**Umcwaningi omkhulu:** Unkosazane B. E. Nzimande

**Umphathi:** Dokotela MN Sibiya,      **Umlekelo womphathi:** Solwazi N Gqaleni

**Isingeniso nenhloso yocwaningo:** Inhloso yocwaningo ukuthola ubudlelwane phakathi kokunakekelwa kwempilo ngendlela yesintu kanye nangendlela yesilungu endaweni yaseThekwini

**Inqubo mgomo:** Uyacelwa ukuthi uphendule umbuzo engizokubuza wona. Ingxoxo yethu izoqoshwa yisiqopha mazwi.

**Ubungozi kobuzwayo:** Abukho ubungozi kulolu cwaningo.

**Imivuzo:** lolucwaningo luhlose ukuqhubekisa ukunakekelwa kweziguli.

**Inzuzo:** Ayikho

**Izizathu ezingenza ukuba obuzwayo aphume ekubeni yingxenye yocwaningo:** Uyacelwa ukuba ungabi yingxenye yocwaningo uma ungenelisekile noma unezinkinga obonayo ukuthi ziyakuvimba ukuba uqhubeke nocwaningo.

**Iholo:** Alikho

**Izindleko zocwaningo:** Azikho

**Imfihlo:** Igama lakho nenombolo yakho yepasi ngeke kudalulelwe ocwaningweni.

**Ukulimala okungatholakala ngesikhathi socwaningo:** Akukho.

**Imininingwane yabantu ongabathinta uma unenkinga noma imibuzo:** Dokotela Sibiya kule nombolo 031-373 2032 noma uSolvazi Gqaleni kule nombolo 031-260 4280.

### **Imvume yokuba yingxenywe yocwaningo**

Mina.....amagama akho aphelele

Inombolo yakho kamazisi....., ngiwufundile wonke lomqulu ngaqonda kahle ingqikithi yawo lapho ebenginezinkinga nemibuzo khona ngichazekile kahle ngichazelwa unkosazana Busisiwe Nzimande ngagculiseka ngokwanele. Ngityaqonda futhi ukuthi ngingaphuma ekubeni yingxenywe yalolucwaningo noma yinini futhi impilo yami ingebe sengcupheni. Ngakho ngiyavuma ukaba yingxenywe yalolu cwaningo.

Igama lobuzwayo (Bhala ngamagama amakhulu).....

Isiginesha yobuzwayo.....Usuku.....

Igama lomcwaningi (Bhala ngamagama amakhulu).....

Isiginesha.....Usuku.....

Ufakazi (Bhala ngamagama amakhulu).....

Isiginesha.....Usuku.....

Igama likamphathi: Dokotela MN Sibiya kanye no Solwazi N Gqaleni (Umsizi kamphathi).

Isiginesha kamphathi.....Usuku.....

Isiginesha kamsizikamphathi.....Usuku.....

### **Appendix 3: Interview guide**

1. How did partnership begin?
2. How does this partnership impact to all parties involved?
3. When do practitioners refer clients, what makes them decide to refer?
4. How do discussions of partnership between traditional and conventional practitioners by both practitioners, like imbizo, happen openly?
5. What is the impact of partnership between traditional and conventional practitioners to the eThekweni District health care system?

## **Isengezo 7b: Inhlolovo ngolwimi lwesiZulu**

1. Baqala kanjani ubudlelwano bokusebenzisana kwabelaphi kwezempilo
2. Basizakala kanjani ababambe iqhaza kulobudlelwano
3. Abelaphi bendabuko bazidlulisela nini iziguli emnyangweni wezempilo wasentshonalanga futhi yini ebona bazidlulise?
4. Zenzeka kanjani izingxoxo ezifana nezimbizo, phakathi kwabelaphi bendabuko nabasentshonalanga?
5. Yimiphi imiphumela eseyenzekile kwezempilo ngokusebenzisana kwalabelaphi esizindeneni saseThekwini?



KWAZULU-NATAL  
TRADITIONAL  
HEALTH  
PRACTITIONERS



**PATIENT REFERRAL FROM THP TO PHC FACILITY / DISTRICT HOSPITAL**  
**INCWADI YOKUDLULISELA ISIGULI EPHUMA KOMELAPHI WENDABUKO IYA ESIKHUNGWENI SEZEMPILO**

**1. Patient Details/ Imininingwane yesiguli**

Patient Reg. No/  
Inombolo yesiguli

Surname/Isibongo

Address/ Ikheli:

First Names/ Amagama

ID Number/ Inombolo  
kamazisi

Age/Date of Birth  
Usuku lokuzalwa

Gender /  
Ubulili

M ☐ F ☐

Tel. No/  
Inombolo yocingo:

Facility where patient usually goes for medical care (first line)/ Isikhungo lapho isiguli sivame  
ukuvashela khona ngosizo lwezempilo (okokuqala)

Hospital/  
Isibhedlela ☐

Clinic/  
Umtholampilo ☐

THP/ Umelaphi  
wendabuko ☐

**2. Details of referring traditional health practitioner/ Imininingwane yomelaphi odlilisele isiguli**

Surname/ Isibongo

Area/Ward/  
Isigceme

Address/  
Ikheli

First Names/  
Amagama

Tel. No. /  
Inombolo  
yocingo

Date/ Usuku

Signature/  
Umsayino

Registration No/  
Inombolo yokulejista

**3. Reason for referral/ Isizathu sokudlulisela:**

1. Medical Unspecified/ Izifo ezinhlobonhlo ☐ 2. STI Screening and /or Treatment/ Ukuhlola izifo zofuba nezikhwehlela ☐  
3. TB Sputum Test/ Ukuhlola nokwelashwa kwezifo zocansi ☐ 4. PMTCT Services/ Ukuvikela ukuthelana kwamama nengane ☐  
5. VCT/ Ukuhlola igciwane lengculazi ☐ 6. Other/Okunye ☐  
Please specify/ Sicela uchaze

4. Current Management/Type of traditional medication given  
Ukunakekelwa kwesiguli njengamanje/uhlobo lomuthi wesintu onikwe isiguli

Tear off here/Dabula lapha

Date/ Usuku: \_\_\_\_\_

**TO BE FILLED IN BY THE DOCTOR OR SISTER IN CHARGE AT THE CLINIC  
KUMELE KUGCWALISWE UDOKOTELA NOMA UNESI WOMTHOLAMPILO:**

*Please complete the following information/ Sicela ugcwalise lemininingwane elandelayo*

Patient name: \_\_\_\_\_ Date patient seen: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Igama lesiguli \_\_\_\_\_ Usuku okubonwe ngalo isiguli \_\_\_\_\_

Patient registration number  
Inombolo yesiguli yokulejista

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Please indicate whether you were able to attend to the patient Yes/Yebo ☐ ~ No/Cha ☐  
Sicela usazise ukuthi ukwazile yini ukusiza isiguli

Contact Number/ Inombolo yocingo:

Name: \_\_\_\_\_  
Igama

Signature: \_\_\_\_\_  
Umsayino

Attending Medical Practitioner/ Udokotela noma unesi obone isiguli \_\_\_\_\_